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African American Women's Construction of Religio-Social Identity in Relation to HIV
and AIDS

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Abstract

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By Tyler J. Fuller

HIV and AIDS disproportionately affect African American communities; particularly women and gay, bisexual, and other men who have sex with men (GBMSM). Seeking to address this public health professionals have implemented HIV and AIDS education and prevention interventions within African American churches because of their importance in their communities. While socio-behavioral research has examined a variety of aspects concerning these interventions, little attention has been given to the narratives that African American churches use to understand HIV and AIDS and construct religio-social identity in the context of the epidemics. Thus, this study utilizes collective memory theory to examine narratives that female African American Christians recall when constructing their identity in relation to HIV and AIDS. Grounded theory guided data analysis of 93 interviews with leaders and members of 20 African American churches in Atlanta, GA, that were gathered as part of a larger HIV prevention intervention study. Diverse teams coded interviews and codes with Cohen's kappa <0.8 were coded to agreement. Analysis of inductive narratives and references of Earvin "Magic" Johnson and men who are on the "down low" (men who are publicly heterosexual but engage in secret homosexual activity) suggest that narratives of men on the down low are used within African American churches to construct a religio-social identity in relation to HIV and AIDS. Magic Johnson's public disclosure of his HIV status helped some participants understand that HIV was not a "death sentence," but it did not contain all the theoretical constructs to be a social identity forming narrative. Inversely, the story of men on the down low articulates the pain of being diagnosed with HIV or AIDS, identifies down low men as responsible for women's pain, and thus African American women as victims. The narrative is also relatable to a wider community of African American women. Theological beliefs about the unacceptability of male-to-male sexual activity appear to aid in constructing this narrative. This analysis suggests that African American communities utilize narratives of men on the down low to understand HIV incidence and prevalence among women and lessen the social and theological culpability of women.

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Introduction

HIV and AIDS disproportionately affect African American women. African Americans who participated in this study within Atlanta, GA, who were predominantly women, perceived African American women as the subpopulation most affected by HIV and AIDS. Yet, epidemiological data does not support this perception (Centers for Disease Control and Prevention [CDC], 2018c). This perception is built on socially constructed narratives that depict African American men on the down low¹ as transmitting HIV to their female partners. Yet, research does not support the perception that the majority of African American women living with HIV acquired it from men on the down low (CDC, 2003; Millett, Malebranche, Mason, & Spikes, 2005; Montgomery, Mokotoff, Gentry, & Blair, 2003). I examine this phenomenon by analyzing qualitative interviews collected as part of a research project examining HIV and AIDS education and prevention interventions² in African American churches in Atlanta, GA. I argue that female African American Christians use this narrative and resulting perceptions about the frequency of HIV and AIDS among African American women, with theological beliefs about male-to-male sexual activity (MTMSA) to construct an identity that is both religious and social in relation to HIV and AIDS.

My contention holds implications, which I will work out in the Conclusion, for working with African American churches to address HIV and AIDS. African American churches are often effective locations to offer HIV and AIDS interventions within African American communities because African American communities trust them and

¹ Men on the “down low” publicly present as heterosexual and often have publicly known female partners but engage in sexual activity with men in secret.

² Henceforth “HIV and AIDS interventions” will describe HIV and AIDS education and prevention interventions unless otherwise noted.

they are equipped to tailor interventions to be culturally and spiritually sensitive (Campbell et al., 2007; J. M. Stewart, Thompson, & Rogers, 2016; Warren & Charles, 2011). Thus, public health practitioners need to understand the cultural and spiritual interpretations of HIV and AIDS in African American churches. Examining the collective memories of HIV and AIDS that African American churches hold is one way of gaining a more nuanced understanding of cultural and spiritual interpretations of HIV and AIDS. Alexander (2004) offers a theory that I will utilize in seeking to do this. His Theory of Signification examines the ways that collective memories and narratives of trauma construct social identities. Alexander's theory suggests that groups use narratives of trauma to construct social identity. In religious contexts, such as African American churches, congregants can construct religio-social identities that use religious beliefs to set up relationships between individuals, the institutional church, and conceptions of HIV and AIDS which inform social interactions, particularly those within the church and among congregants.

This research utilizes interviews with African American church leaders and members in Atlanta, GA to examine how perceptions of HIV and AIDS, in conjunction with theological beliefs, construct religio-social identity. The driving research question for this study is: how do female African American Christians re-member³ and define HIV and AIDS when constructing a religio-social identity? Seeking to answer this question, I examine the ways that African American women's collective social identity in relation to

³ Erll (2011) describes re-membering as, "an act of assembling available data that takes place in the present... Individual and collective memories are never a mirror image of the past, but rather an expressive indication of the needs and interests of the person or group doing the remembering in the present" (p. 8).

HIV and AIDS is constructed within churches, using theological understandings of appropriate sexual behavior and MTMSA.

In Chapter 1, I lay a foundation for understanding the importance of this question. I identify a problem, that HIV and AIDS both highly and disproportionality African American communities in the United States (U.S.). I contextualize the problem by examining why it is important to study HIV and AIDS in African American churches and what public health interventions have been utilized to address HIV and AIDS in African American churches. I then contextualize this study by examining the history of HIV and AIDS in African American communities and churches. Finally, I prepare to move into the research question and theoretical paradigm by examining how communities and American society socially construct HIV and AIDS.

Having identified a problem and contextualized it practically, historically, and socially, in Chapter 2 I move on to describing the theories and methods that I will use in this research. I first describe the theoretical paradigm I utilize to examine how African American communities construct religio-social identity. First, I describe how Maurice Halbwachs' understandings of collective memory informs how I qualitatively investigate religio-social identity construction. Second, I examine Emilie Townes' understanding of counter-memory, which I suggest applies to the narrative I examine and which I utilize when forming conclusions based on my analysis. Third, I examine Jeffery Alexander's Theory of Signification, which I use in the Chapter 4 to analyze the narratives described in Chapter 3. After I establish this theoretical foundation, I describe how researchers gathered the interviews analyzed here and how I analyzed them in this study.

In Chapter 3, I follow four themes that emerged as part of data collection and analysis. I describe participants' initial understandings of HIV and AIDS. Then I describe two narratives that emerged inductively during analysis; that is, interviewers did ask participants about them, but a number of participants utilized them when answering a variety of questions. The first of these inductive narratives describes Earvin "Magic" Johnson's public disclosure of his HIV status. This is important because public health and sociology researchers have examined this event as a way that African Americans understand HIV and AIDS. The second narrative describes men on the down low transmitting HIV to African American women. Finally, I examine answers to questions that specifically asked about homosexuality, because theological beliefs about MTMSA described in response to these questions were closely linked to participants' narratives of men on the down low.

In Chapter 4, I tie together the threads that have been laid out in Chapters 1-3. I examine how the two inductive narratives described meet or diverge from the constructs of Alexander's Theory of Signification. I examine pain that is experienced in relation to HIV and AIDS; who acquires HIV, their experience of their diagnosis, and their social relationships after their diagnosis; who shares narratives of HIV and AIDS within African American communities; and how African American churches, as social institutions, frame who is held responsible for experiences of HIV and AIDS within their communities.

In the Conclusion, I summarize my findings from Chapter 4 and contextualize them within the Chapter 1 and Chapter 2's Theoretical Paradigm sections. Specifically, I reflect on the implication of African American women telling narratives of men on the

down low in churches to construct religio-social identity around acceptable HIV and AIDS. I offer some implications that this research has for conducting HIV and AIDS interventions in African American churches, particularly for women. I also recognize the limitations of this study, including the fact that I am a white man studying African American women and attempting to understand their lived experiences and memories, which are outside of my own social location.

Chapter 1: HIV and AIDS in African American Communities and Churches

HIV and AIDS are important public health concerns to address in the U.S. and African American communities are disproportionately affected. Over one million Americans 13 or older were living with HIV at the end of 2015 with only an estimated 85% whose infection had been diagnosed (CDC 2018c). African Americans account for 43% of the 38,739 new HIV infections during 2017, but make up only 13% of the US population (CDC, 2018a, 2018b). During 2017, African Americans had the highest incidence⁴ of new HIV diagnoses and had the highest rate of new HIV diagnoses among the seven racial/ethnic groups that the Centers for Disease Control and Prevention (CDC) track. African Americans had a rate of 41.1 new diagnoses per 100,000 people, over 2.5 times more new diagnoses per 100,000 people than the racial/ethnic group with the next highest rate (CDC, 2018a).⁵ They are also highly affected by AIDS, having the most new AIDS diagnoses in 2017 out of the seven racial/ethnic groups tracked and also having the highest cumulative number of persons diagnosed with AIDS since the beginning of the epidemic through 2017 (CDC, 2018a). This indicates that African American communities are highly affected by HIV and AIDS.

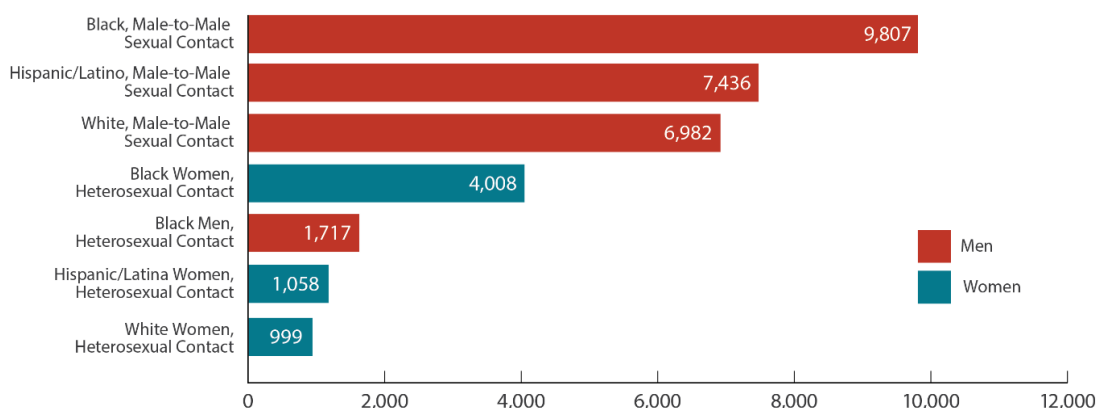
Nationally, African American subpopulations accounted for three of the five most affected subpopulations in 2017, adding nuance to understandings of who within the African American community is most highly affected by HIV (Figure 1; CDC, 2018c).⁶

⁴ “The [incidence] of a disease is defined as the number of new cases of a disease that occur during a specified period of time in a population at risk for developing the disease” (Gordis, 2014).

⁵ Hispanic/Latinos had the second highest rate of new diagnoses with 16.1 new HIV diagnoses per 100,000 people.

⁶ Although imperfect, in this study I follow the precedent set by the CDC (2018a) and utilize HIV prevalence and incidence to identify which subpopulation is the most affected by HIV and/or AIDS.

Figure 1. New HIV Diagnoses in the US for the Most-Affected Subpopulations, 2017



Note. From “HIV in the United States” by Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, 2018, <https://www.cdc.gov/hiv/statistics/overview/atagance.html>. Accessed 01/13/2019.

African American gay, bisexual, and other men who have sex with men (GBMSM)⁷, heterosexual women, and heterosexual men each had a high incidence of new HIV diagnoses in 2017, respectively. African American GBMSM experienced the highest amount of new diagnoses in 2017, making them the subpopulation in the US that is currently the most affected by HIV. African American women are disproportionately affected by HIV when compared to all women with more than 60% of all female

⁷ Terminology used to identify “homosexual,” “gay,” “men who have sex with men,” or “same gender loving men” has been the subject of debate within recent years. Within social science and public health literature the term “men who have sex with men” (MSM) was adopted to avoid identifying individuals as “gay” who may not self-identify as “gay,” but more recently there has been pushback from the gay community that this strips individual of their social identity and reduces them to their sexual behavior (Young & Meyer, 2005). In this study I use the phrase “gay, bisexual, or other men who have sex with men” in an (imperfect) attempt to recognize the ways that both identity and behavior may mutually or independently be relevant in understanding beliefs, practices, and lived experiences. Within the African American community, the term “same gender loving men” has been proposed as an alternative that is culturally relevant, although it is yet to be widely used in public health literature and some research suggests that it is not yet widely used among African American men (Malebranche, Peterson, Fullilove, & Stackhouse, 2004).

diagnoses of HIV belonging to African American women; they also make up the most affected non-MSM population (CDC, 2018b). While heterosexual African American women and men are each also highly affected, African American GBMSM had over 2.4 times as many new HIV diagnoses in 2017 when compared to African American women. A decrease in HIV incidence from 2010 – 2016 has been reported, predominantly driven by a 21% decline in new infections among African American women and the number of new infections among African American GBMSM maintaining a steady rate (CDC, 2019).

HIV and AIDS particularly affect the South. In 2017 the South had the highest rate of new HIV diagnoses of the four regions that the CDC track with 19,968 new HIV diagnoses and a rate of 16.1 new diagnoses per 100,000 people; this (CDC, 2018a).⁸ Georgia in particular, was the state (excluding the District of Columbia) with the highest rate of new HIV diagnoses in 2017 (CDC, 2018a). Atlanta, GA had the third highest incidence of new HIV diagnoses among metropolitan areas in the US in 2017 (CDC, 2018a).

Within the South, African Americans are particularly affected by HIV; in 2017 over half of new diagnoses in the region were among African Americans (CDC, 2018a). In Atlanta, GA African American women are impacted by HIV. About one third of the population of Atlanta is Black, yet Black Atlantans accounted for 73.8% of new HIV diagnoses from 2013-2017 (AIDSVu, 2019) Among women living in Atlanta, the rate of African American women living with an HIV diagnosis is 15 times that of white women

⁸ The region with the second highest rate of new diagnoses was the Northeast with 10.6 new diagnoses per 100,000 people.

(AIDSVu, 2019). This indicates that African American women are in need of HIV and AIDS education, prevention, testing, and care services.

HIV and AIDS are important issues in African American communities, particularly in the South, and so is religion. African American churches are recognized as important social institutions within their communities (Lincoln & Mamiya, 1990). Data that the Pew Research Center gathered in 2014 in Georgia reported that among African American adults, 77% say religion is “very important” in their lives (PRC, 2019b) and 47% attend a religious service at least once a week (PRC, 2019a), and 44% believe that homosexuality should be discouraged (PRC, 2019b). The importance of religion in African Americans’ lives and their religious service attendance make African American churches in Atlanta potential partners for HIV and AIDS interventions.

HIV and AIDS Interventions in African American Churches

African American churches have been important locations for HIV and AIDS interventions since 1987, when the CDC began to reach out to African American faith-based groups through the Black Faith Initiative, because of the importance that these churches hold in their communities (CDC, 2011b). Churches have been recognized as important locations and figures in the civil rights movement and in social change (Lincoln & Mamiya, 1990). Because of this, African American churches are places where health interventions can take place. Public health practitioners have created guides for working with African American churches (Campbell et al., 2007; Warren & Charles, 2011) and a growing body of research has been conducted looking at the role of both church- and faith-based HIV, AIDS, and sexual health promotion in African American communities (Abara, Coleman, Fairchild, Gaddist, & White, 2015; Berkley-Patton et al.,

2010; Berkley-Patton et al., 2016; Derose et al., 2011; J. Stewart, Budhathoki, Thompson, & Hamilton, 2017; J. M. Stewart et al., 2016; Wingood et al., 2013; Wingood, Simpson-Robinson, Braxton, & Raiford, 2011).

HIV and AIDS interventions in African American churches have shown positive results with research citing the cultural and leadership roles of the church as reasons for intervention success. Churches have been shown to be trusted by African American communities and are convenient locations for them to access health interventions (Abara et al., 2015; Berkley-Patton et al., 2016; Campbell et al., 2007; J. Stewart et al., 2017; J. M. Stewart et al., 2016). Church leader involvement has been reported to be important in HIV and AIDS prevention and testing interventions in African American churches (Berkley-Patton et al., 2016; Derose et al., 2011). Research has also reported that church-based interventions are effective in providing knowledge, skills, and increasing HIV testing (Berkley-Patton et al., 2016; Wingood et al., 2013; Wingood et al., 2011). It has also been reported that when churches have HIV and AIDS programs, they often partner with community based HIV and AIDS prevention and service organizations (Derose et al., 2011).

Several factors are associated with how churches perceive HIV and AIDS interventions. Region of the country, age of clergy, pre-existing health programs, having a church member who is openly living with HIV, and having a person to lead efforts to address HIV related issues have all been associated with predicting the likelihood of an African American congregation having an HIV and AIDS program (Abara et al., 2015; Coleman, Lindley, Annang, Saunders, & Gaddist, 2012; J. Stewart et al., 2017). Stigma against premarital sexual activity, contraception use, or homosexuality are often

described as a barrier to African American churches having HIV and AIDS education and prevention programs (Coleman et al., 2012; Derose et al., 2011; Smith, Simmons, & Mayer, 2005).

How public health practitioners talk to church leaders about HIV and AIDS interventions has received some attention in the literature but is predominantly confined to methods sections and is not often part of the main discussion of articles. One exception of this comes from Abara et al. (2015) who reported success in implementing HIV and AIDS prevention interventions in South Carolina by highlighting: the burden of HIV on the community, the role of the church in mitigating this burden, and opportunities the intervention provided to address the burden. They also reported using targeted, culturally competent terminology that was age and gender specific to address facts about HIV, but do not report on what that terminology was (Abara et al., 2015). Other interventions report success using transparent communication, building relationships, reminding religious leaders of personal experiences meeting people living with HIV/AIDS, and placing an emphasis on church values that highlight the responsibility of the church to promote health (Campbell et al., 2007; Derose et al., 2011; Odulana et al., 2014; Warren & Charles, 2011; Wingood et al., 2013; Wingood et al., 2011). Few articles in the literature address how public health practitioners frame the issue of HIV/AIDS prevention programs or the terminology they use when discussing these programs with church leaders.

Having examined why it is important to address HIV and AIDS in African American communities and how African American churches have been utilized in efforts to implement HIV and AIDS interventions I now turn to examining the history of the

HIV and AIDS epidemics within African American communities at large. This examination is important as it lays a foundation and contextualizes the later narratives of HIV and AIDS within African American churches that will be described in the Results section and Discussion of how these narratives are part of how African American Christian women construct religio-social identity in relation to HIV and AIDS.

African American Communities and the HIV and AIDS Epidemics

While white, gay men have often been the face of the HIV and AIDS epidemics in America, African Americans have been affected by both epidemics since AIDS was first being reported in 1981 (CDC, 2011b). The CDC states that, “although AIDS was often considered a problem of white gay men, African Americans have been hard-hit by the disease since the earliest days of the epidemic” (CDC, 2011a). AIDS may have been first reported among five white, gay men, but in about a year 20% of AIDS diagnoses were among African Americans (CDC, 1981, 2011a, 2011b). African American communities have always been affected by AIDS and by 1988 they were considered to be disproportionately affected by AIDS as the number of new diagnoses exceeded the number of new diagnoses among whites, a problematic legacy that continues today (CDC, 1989, 2011b, 2018b).

Early discussions of how AIDS affected African American communities were largely initiated by African American scholars. Mays and Cochran (1988) recognized that African American women were seriously affected by AIDS, yet women did not always perceive this due to cultural narratives regarding AIDS being a white, gay man’s disease and low health literacy regarding behaviors that put individuals at risk for acquiring HIV. Dalton (1989) wrote about AIDS through a critical race perspective, seeking for white

America to acknowledge the role that slavery, segregation, and racism played in the AIDS epidemic. Thomas and Quinn (1991) argues that the Tuskegee Syphilis Study, in which African American men living with syphilis were not treated while being observed for years so that white medical doctors could learn about the progression of syphilis, is a “historical marker for the legitimate discontent of Blacks with the public health system” (p. 1504). Thomas and Quinn take seriously the conspiracy theories present within African American communities at this time, seeking to understand the lived experiences and truths they held rather than to dismiss them as being scientifically unfounded. Gamble (1997) further examined how memory of the Tuskegee Syphilis Study informed questions within African American communities about if AIDS was “part of a conspiracy to exterminate African Americans” (p. 1775).

While African American communities were beginning to be recognized for the unique AIDS burden they bore, much of the white American public still saw AIDS as being a white, gay man’s issue. Moving forward the early 1990s brought more public acknowledgment of AIDS within African American communities. In 1991 African American, professional basketball player Earvin “Magic” Johnson publicly announced that he was living with HIV and in 1992 African American, professional tennis player Arthur Ashe publicly announced that he was living with AIDS (CDC, 2011b). Johnson came out as HIV positive in a time when HIV and AIDS were often seen as a “gay disease.” Yet he also sought to reframe that understanding through sharing his narrative. In the press conference he came out during he said, “I think sometimes we think, well, only gay people can get it – ‘It’s not going to happen to me.’ And here I am saying that it can happen to anybody, even me, Magic Johnson” (quote cited in Stevenson, 1991).

Shortly after, in November 1993 HIV and AIDS became the leading cause of death for young African American men (CDC, 2011b). The amount of academic literature examining AIDS among African Americans increased in 1993, examining women (Quinn, 1993), communities' perceptions of AIDS (Herek & Capitanio, 1993; Quimby, 1993; Randolph & Banks, 1993), and AIDS education and prevention interventions for youth (Damond, Breuer, & Pharr, 1993).

Transitioning from the late 1990s into the early/mid 2000s research on HIV and AIDS within African American communities took a turn, to examine the role that risk factors played in understanding and preventing the spread of HIV. Much of the research focused on promoting condom use among African American women (Beatty, Wheeler, & Gaiter, 2004; Burns & Dillon, 2005; Jipguep, Sanders-Phillips, & Cotton, 2004; McNair & Prather, 2004; McNair & Roberts, 1997; Winfield & Whaley, 2005), a change from the late 1980s, when it was thought that women were primarily infected through intravenous drug use (Quinn, 1993). Although some research continued to examine intravenous drug use among women (Jones, 2004).

Another area of research that was addressed was meeting the needs of African American GBMSM (Beatty et al., 2004; Mays, Cochran, & Zamudio, 2004), although much of the research within this community was addressed at understanding the perceptions and behaviors of men on the down low (Martinez & Hosek, 2005; Millett et al., 2005). This shift may reflect discussions and understandings of HIV, AIDS, and sexuality within African American communities because it was not limited to academic discourse but was also part of popular cultures. In April, 2004 *The Oprah Winfrey Show* aired "A Secret Sex World: Living on the Down Low," where Oprah interviewed J.L.

King, who had previously lived on the down low, and linked being on the down low to AIDS telling her viewers being in a relationship with a man on the down low “can also be life-threatening to you and your partner” (Oprah, 2004). After the show research into how African American GBMSM on the down low were related to HIV and AIDS rates in African American communities proliferated. In particular it often examined how “the down low” is defined and understood, and what implication this has for research (Ford, Whetten, Hall, Kaufman, & Thrasher, 2007; Malebranche, 2008; Saleh & Operario, 2009; Sandfort & Dodge, 2008)

Looking from 2008 – the present, a focus of public health inquiry regarding HIV and AIDS in African American communities has shifted from who is transmitting HIV to how to educate communities about HIV and AIDS. One area that has received ongoing examination during this period is how to conduct HIV and AIDS interventions in African American churches.

The Social Construction of HIV and AIDS

The language that public health practitioners use when introducing HIV and AIDS interventions to African American congregations is important. In *How to Have Theory in an Epidemic* Treichler (1999) argues that AIDS⁹ is not a biomedical reality that we can understand apart from its social construction. Scientists, doctors, public health practitioners,¹⁰ politicians, clergy, community members, and broader society all

⁹ Until the advent of multi-drug therapies there was little use of identifying HIV separately from AIDS, as it would always lead to AIDS. Now, with effective therapies individuals can live with HIV for long periods of time without developing AIDS.

¹⁰ Treichler asserts that even biomedical understandings of HIV and AIDS were informed by scientists, doctors, and public health practitioners social realities saying, “Our social constructions of AIDS (in terms of global devastation, the threat to civil rights, the emblem of sex and death, the “gay plague,” the postmodern condition, whatever) are based not on objective, scientifically determined “reality” but on what

reciprocally influence and are influenced by the growing number of social constructions of AIDS' ontological nature, what Treichler calls an "epidemic of signification."

Treichler explains this saying,

Moreover, the term AIDS has come to be linked to a series of preexisting worldviews, institutional discourses, material realities, and cultural phenomena – which in turn represent a range of positions and interests, draw on multiple resources and strategies, originate from different places within culture, and point toward different strategies for treatment and control. Although "AIDS" is new, it is already peopled. (1999, p. 316)

These varieties of social constructions necessitate that public health practitioners and African American religious leaders engage in dialogue about the meaning of HIV and AIDS within African American congregations and communities in order to inform effective HIV and AIDS interventions.

Initial constructions of AIDS in the U.S. focused on its social location within homosexual male bodies. Initial names for the new phenomenon in 1981 included "Gay-Related Immunodeficiency" and "Wrath of God Syndrome," with the former suggesting that AIDS' etiology was ontologically homosexual and the later, built on a similar foundation, that AIDS was a punishment from God for engaging in the sin of MTMSA (Treichler, 1999, p. 27). Drawing on Turner (1984, p. 209), Treichler posits that "(1) disease is a language; (2) the body is a representation; and (3) medicine is a political practice" (1999, p. 36). These three concepts are exemplified in "discursive dichotomies" that she offers of how AIDS has been constructed to "other" those who live with it, often in ways that further remove GBMSM from American society. Treichler states:

we are told about this reality: that is, on *prior* social constructions routinely produced within the discourses of biomedical sciences" (1999, p. 15)

We inherit a series of discursive dichotomies; the discourse of AIDS attaches itself to these legacies of difference and reinvigorates them:
 Homosexual and heterosexual;
 Homosexual and “the general population”;
 Vice and virtue;
 Prostitute and paragon;
 Whore and wife;
 Contamination and cleanliness (1999, p. 35).¹¹

These are social constructions of what it means to live with AIDS, but they are also political and moral statements that set up GBMSM as the “other.” Because of the political undertones of these othering descriptions some GBMSM pushed for AIDS to be seen as a societal phenomenon that was impacting more than just the gay community. Such a push was in some ways needed to gain more governmental attention to the AIDS crisis but was also not entirely effective.

Treichler draws attention to the reality that medical, media, and public discussion of AIDS often viewed it as a gay man’s disease, discounting the experiences women had living with AIDS. When women were discussed as being affected by AIDS it was often within the contexts of prostitution or promiscuity. In many ways this mirrored the assumptions linked to gay men living with AIDS: that they became HIV positive because they were engaging in immoral sexual behaviors. Efforts to provide AIDS education to girls and women were short lived, which not only were informed by perceptions of who could get AIDS and how it was transmitted but also informed public perceptions of these as well. Treichler offers commentary on this saying,

In the discourse of the AIDS epidemic, we see reenacted many of the semantic and regulatory battles that have marked relations between women and biomedical

¹¹ This list represented a portion of the dichotomies that Treichler identifies but is made up of examples from a larger list. In a confusing move, Treichler uses the word “and” to connect dichotomies, rather than “versus,” even though she clearly identifies these as dichotomies, which by definition are ontologically different or opposed.

science for at least the last century – but with a difference. To sum this up crudely, when female prostitutes (and other “promiscuous” women) missed their cue to enter this latest venereal drama, biomedicine gave their role away to homosexual and bisexual men... To put this somewhat differently, once scientists decided that female-to-male sexual transmission of infection was less likely than male-to-male or male-to-female transmission, “heterosexual transmission” dropped out as a major plot element in stories of the epidemic. (1999, p. 45)

Since this time there has been a need for further HIV and AIDS interventions for women, but popular consensus has often been that they do not need it because they are not susceptible to HIV or only acquire it through immoral sexual activity. In an analysis that sounds like it could have been written recently, two decades later, Treichler also offers that,

... almost twenty years into the epidemic women diagnosed with HIV or AIDS – and sometimes their physicians as well – still express astonishment at finding themselves with a “gay man’s disease.” At the same time, in the United States in the late 1990s, the quantitative burden of this epidemic continues to be borne by gay men, and, today, with recognition of the profound irony of the move, the very communities who labored throughout the 1980s to disarticulate “AIDS” from “gay male sexuality” are striving to “re-gay” AIDS so that resources will not be withdrawn when they are as needed as ever. (1999, p. 48)

Treichler examines the ways that definitions of AIDS were constructed from the 1980-90s and the effects of these definitions of a societal level. Though her work she brought forward narrative and memories of AIDS that were not part of public dialogues regarding AIDS. Her assertion is that it is important to understand how these narratives and definitions are social constructed. She contends that,

In AIDS, where meanings are overwhelming in their sheer volume and often explicitly linked to extreme political agendas, we do not know whose meaning will become “the official story.” We need an epidemiology of signification – a comprehensive mapping and analysis of these multiple meanings – to form the basis for official definition that will in turn constitute the policies, regulations, rules, and practices that will govern our behavior for some time to come. As we have seen, these may rest on “facts,” which in turn may rest on the deeply entrenched cultural narratives that I have been describing. For this reason, what AIDS signifies must be democratically determined: we cannot afford to let

scientists or any other group of experts dismiss our meanings as “misconceptions” and our alternative views as noise that interferes with the pure processes of scientific inquiry. Rather, we must insist that many voices contribute to the construction of official definitions – and specifically certain voices that need urgently to be heard. (Treichler, 1999, p. 39)

Two decades after her writing we can observe that a highly promulgated, if not “official,” societal definition of AIDS was formed by scientists, doctors, and public health practitioners.¹² Yet, other definitions still exist in the memories of individuals, communities, and social groups that are not readily recognized by those working from biomedical paradigms.

The importance of this work to the present study is the ways that it describes how HIV and AIDS are socially constructed. Social construction of a concept, definition, or identity always happen within social relationships to other concepts, definitions, or identities, thus it is useful to examine the ways that HIV and AIDS are defined in African American churches in relation to African American women’s construction of a social identity in relation to HIV and AIDS.

Research Aim and Question of this Study

Epidemiological data indicates that African Americans living in Atlanta, GA are highly impacted by HIV and AIDS. As public health professionals continue to implement HIV and AIDS intervention to address this, the role of African American churches as centers of social life and constructing models of meaning making cannot be overlooked.

¹² The US Department of Health and Human Services (HHS) and the World Health Organization (WHO) both indicate in their mission statements that they support holistic well-being, although the HHS does not take quite the anthropological approach to understanding health that WHO does (HHS, 2017; WHO, 2017a). Yet, both also only list biomedical information about HIV and AIDS on their webpages about these topics (HHS, 2017; WHO, 2017b).

Studying the ways that churches aid in constructing religio-social identity can help public health professionals develop culturally and spiritually sensitive and effective programs.

I aim to examine the ways that African American women construct definitions of HIV and AIDS, informed by theological and ethical ways of making meaning, and form identities in relation to these definitions, within the context of African American churches. To do this I seek to answer the question, how do female African American Christians re-member and define HIV and AIDS when constructing a religio-social identity? To answer this, I will examine memories of HIV and AIDS through analyzing interviews given by leaders and members of African American churches in Atlanta, GA. In the next section I will define the theoretical paradigm and constructs that I employ to answer this question.

Chapter 2: Utilizing Collective Memory to Examine Narratives of HIV and AIDS in African American Churches

This study seeks to understand how female African American Christians define HIV and AIDS and create an identity in relation to HIV and AIDS that is both religious and social. In the Introduction I addressed why HIV and AIDS interventions are needed in African American communities in Atlanta, GA, as well as why African American churches are effective places to host these interventions. I also briefly reviewed how HIV and AIDS have impacted African American communities and how these communities have responded to HIV and AIDS. Finally, I drew on the work of Paula Treichler, who discussed the social construction of HIV and AIDS, to frame the question how do female African American Christians re-member and define HIV and AIDS when constructing a religio-social identity?

In this chapter I will first provide the theoretical paradigm that this study occurs within and then describe the methods utilized in this work. I begin by recognizing the contributions of Maurice Halbwachs, who was the first to examine memory on a social level, to show why it is appropriate to use qualitative research in this endeavor. I then make a shift and draw on Emilie Townes, who described the ways that marginalized groups form memories that react to hegemonic narratives, which I contend the narratives in this study do as well. Finally, I discuss Jeffery Alexander's (2004) Theory of Signification, which provides the constructs which I utilize in Chapter 4 to analyze narratives which are presented in Chapter 3.¹³

¹³ I recognize that building a theoretical framework based off of the work of two white men (Halbwachs and Alexander) does pose a certain limitation because they are not members of the social group that this project is examining. Halbwachs is the foundational theorist in the study of collective memory and thus this

Theoretical Paradigm of this Study

Erll (2011) highlights the emergence of memory studies, explaining that “both the practice of remembering and reflection on that practice have become an all-encompassing sociocultural, interdisciplinary, and international phenomenon” (p. 1). A number of different fields draw on memory studies, including religious studies, sociology, and psychology. Socio-behavioral public health research is also grounded strongly in sociology and psychology, making memory studies a useful bridge between religious studies and public health research.

This study’s research question seeks to understand Female African American Christians’ lived experiences encountering or learning about HIV and AIDS, how their memory and understandings of HIV and AIDS is both informed by current contexts and informs how they view current contexts, and how they utilize memory to negotiate and construct a collective religio-social identity. This study utilizes an overarching interpretive paradigm because it is an effective paradigm for examining lived experiences and memory within social structures. An interpretive paradigm is postmodern and seeks “to understand people’s lived experience from the perspective of people themselves” (Hennink, Hutter, & Bailey, 2010, p. 14). Interpretive paradigms often inform qualitative research and can also include phenomenological and hermeneutical epistemologies. An interpretive paradigm is useful for answering the research questions examined here because it seeks “to get at the lived experience ... requires a method which is phenomenological, giving a deep insight into the essence of the experience, and which is

theoretical paradigm would be incomplete if I did not draw on him. Alexander offers a theory of how perceived social trauma forms collective identity, a pursuit that I have not yet seen from a female African American scholar.

hermeneutical, providing the tools to interpret and understand the experience” (Swinton & Mowat, 2016, p. 55).

Individual and Collective Memory

Within an overarching interpretive paradigm, this research is grounded in Maurice Halbwachs’ theory of collective memory (1992). Halbwachs’ theory utilized a constructivist epistemology, describing how individual and social structures act reciprocally to form collective memory and emphasizes phenomenological epistemology. Halbwachs’ theory “sees even the most personal memory as a [collective memory], a collective phenomenon” (Erl, 2011, p. 14). Personal memories are informed by the social context of the person, both the contexts where the memory was first formed and where it is re-membered (Halbwachs, 1992, pp. 52-53). Yet, social contexts are also informed by personal memories because each individual memory is held within the collective memory, holding a place within the conformity or diversity of memory. Halbwachs describes how this links to social identity saying, “We preserve memories of each epoch in our lives, and these are continually reproduced; through them, as by a continual relationship, a sense of our identity is perpetuated” (1992, p. 47)

Halbwachs also described the role of intergenerational memory as a means of memory transmission within groups and the construction of social identity (1992, pp. 77-78). His understanding of intergenerational memory is grounded in constructivist and hermeneutical epistemologies because, “[intergenerational memory] is constituted through social interaction and communication” (Erl, 2011, p. 17). Intergenerational memory focuses on how older members of social groups interpret and then share memories with younger members, often using oral history and narrative. Younger

generations must interpret memories shared with them which are both informed by the social context and help to construct their social identity. Through this process, groups' social identities and realities are constructed, based on interpretation of lived experiences: both the interpretation of the older generations in passing on the memory and of the younger generations in receiving and utilizing the memory.

For Halbwachs, collective memory is different than history because of its ability to construct social identity. History is seen as an accurate, yet passive representation of the past, as separate from memory. But history does little when trying to understand group perceptions and interpretations of the past. For Halbwachs, memory is active in lived experience and society. Answering a very different kind of question than history, memory seeks to understand the “needs and interests of the group in the present, and thus proceeds in an extremely selective and reconstructive manner” (Erl, 2011, p. 17). Thus, like Swinton and Mowat (2016), Halbwachs' understanding of memory helps researchers to understand individuals' and communities' lived experiences and their interpretations.

The Fantastic Hegemonic Imagination and Countermemory

Mirroring the distinction that Halbwachs draws between history as passive facts and memory as active in lived experience, Emilie Townes (2006) begins her work by reflecting on Toni Morrison's distinction between fact and truth, that “fact can exist without human intelligence, but truth cannot...” (Morrison, 1998, pp. 193-194). The distinction juxtaposes passive history and facts against memory and truths that are active in individual and communal life. This draws attention to the way that memory holds truth, telling us something profound about how individuals and communities experience the world.

Townes utilizes memory to move beyond looking at history as social reality and to seek out the truth of lived experience through memory. She does not want to do away with history, but rather recognizes that what is now deemed as “history” is often the narratives, perceptions, and collective memories of dominant social groups (white people in America) and sees memory as a way to listen to and bring the voices of minority and oppressed groups to the conversation.

Townes brings forth two theoretical constructs that are important for the theoretical paradigm at hand: the fantastic hegemonic imagination and countermemory. The fantastic hegemonic imagination is a societal narrative that is established by a dominant social group that minority and oppressed groups are expected to accept. These narratives go against their lived experience, yet also become part of the social context that reciprocally informs their interpretation of lived experiences. Townes describes it saying,

The fantastic hegemonic imagination traffics in peoples’ lives that are caricatured or pillaged so that the imagination that creates the fantastic can control the world in its own image... The fantastic hegemonic imagination uses a politicized sense of history and memory to create and shape *its* worldview... These images have an enormous impact on how we understand the world, as well as others and ourselves in that world. Subjugation and consent sashay to deadly images that are largely unchecked until they lose their force and are replaced by more deadly and sinister images such as the movement from the Black Matriarch to the Welfare Queen. It is important to note at this point that the fantastic hegemonic imagination is in all of us. It is no respecter of race... It is not bound by gender or sexual orientation... None of us naturally escape it, for it is found in the deep cultural codings we live with and though in the U.S. society. (Townes, 2006, p. 21)

For Townes, the resolution to the problem of the fantastic hegemonic imagination is countermemory, subversive memories that highlight the lived experiences and social realities of minority and oppressed peoples. For Townes,

Counteremory begins with the particular to move into the universal and it looks to the past for microhistories to force a reconsideration of flawed (incomplete or vastly circumscribed) histories... Counteremory can open up subversive spaces within dominant discourses that expand our sense of who we are... (2006, pp. 22-23)

Engaging in counteremory groups can recall how individual lived experiences have shaped their collective social experience and break down hegemonic narratives that are proliferated and reinforced by society, opening up space for dialogue that is intersectional and thus recognizing their lived experiences.

I argue that African American women and African American GBMSM engage in counteremory that pushes against white, patriarchal, heteronormative hegemony. White, heteronormative people are granted privilege in American society, of which one privilege is that they do not have to routinely contend with HIV and AIDS as being realities within their communities. They can reflect on the HIV and AIDS crises when they see a story in the news or come across it in another forum, but they need not dwell on it long because society has constructed an identity and an environment for them that is separated from the social realities of living with HIV and AIDS (Treichler, 1999, pp. 2-3; Watney, 1994). The incidence and prevalence¹⁴ of HIV and AIDS among African American women, and African American GBMSM preclude them from the privilege of ignoring the HIV and AIDS epidemics. Yet, these communities also exist within a society that largely does not consider HIV and AIDS, and when it does it largely attributes it to the history of the white, gay men, due to promiscuity. This hegemonic narrative has shaped much public discourse about HIV and AIDS within America since the 1980s. The

¹⁴ “Prevalence is defined as the number of affected persons present in the population at a specific time divided by the number of persons in the population at that time, that is, what proportion of the population is affected by the disease at that time?” (Gordis, 2014).

narratives that African American Christians share in this qualitative research is counter-memory because they push back against the hegemonic narrative and its accompanying fantastic imagination that only promiscuous and/or white, gay men are affected by HIV and AIDS.

Social Trauma and Cultural Narratives

Jeffrey Alexander (2004) offers the theory of signification which he uses to identify how social actors tell narratives of cultural trauma and thus construct social identity. He does not seek to place a rigid definition on what is a “trauma,” but asserts that cultural groups define which events are or are not traumatic based on if the event disrupts their sense of identity or cultural forms of meaning making.

Identity involves a cultural reference. Only if the patterned meanings of the collectivity are abruptly dislodged is traumatic status attributed to an event. It is the meanings that provide the sense of shock and fear, not the events in themselves...For traumas to emerge at the level of the collectivity, social crises must become cultural crises. Events are one thing, representations of these events quite another. Trauma is not the result of a group experiencing pain. It is the result of this acute discomfort entering into the core of the collectivity’s sense of its own identity. Collective actors “decide” to represent social pain as a fundamental threat to their sense of who they are, where they came from, and where they want to go. (Alexander, 2004, p. 10)

In this definition we may consider how the HIV and AIDS epidemics are traumas for African American communities. Alexander’s theory offers a way of examining what the “discomfort” that affects “the collective’s sense of its own identity” is; what is it about HIV and AIDS that affects how African American communities understand themselves?

Trauma informs and shapes social identity through a process of group representatives making claims of trauma for the group and the broader public. The theory of signification identifies four main constructs that take place, temporally, between the

event in question and public representation and recognition of the event (Figure 2, p. 30). The first is the carrier group and their social actors. “Carrier groups have both ideal and material interests, they are situated in particular places in the social structure, and they have particular discursive talents for articulating their claims – for what might be called ‘meaning making’ – in the public sphere” (Alexander, 2004, p. 11). Carrier groups and social actors share narratives of trauma with others so that they can be taken up within social groups as meaningful narratives.

Second, carrier groups articulate claims about events that are absent from public discourse and representation. Claims are symbolic representations and characterizations about “some fundamental injury, an exclamation of the terrifying profanation of some sacred value, a narrative about a horribly destructive social processor, and a demand for emotional, institution, and symbolic reparation and reconstitution” (Alexander, 2004, p. 11). Claims must articulate four things: (1) they must articulate “the nature of the pain,” explaining what happened; (2) they must bring forward “the nature of the victim,” answering questions about who was affected by the event being described; (3) they “[relate] the trauma victim to the wider audience,” to effectively take up a claim an audience must have some sense of relationship with the victim and the event; and (4) they must assign responsibility for the trauma to an individual or group (Alexander, 2004, pp. 13-15).¹⁵ For these claims to form a new “master narrative” they must be taken up by the audience they are presented to.

Yet this storytelling is, at the same time, a complex and multivalent symbolic process that is contingent, highly contested, and sometimes highly polarizing. For

¹⁵ Townes’ countermemory are a subcategory of these claims; they are narrative experiences about events that are absent from the public discourse, but they are special in that they specifically resist claims made by hegemonic discourse.

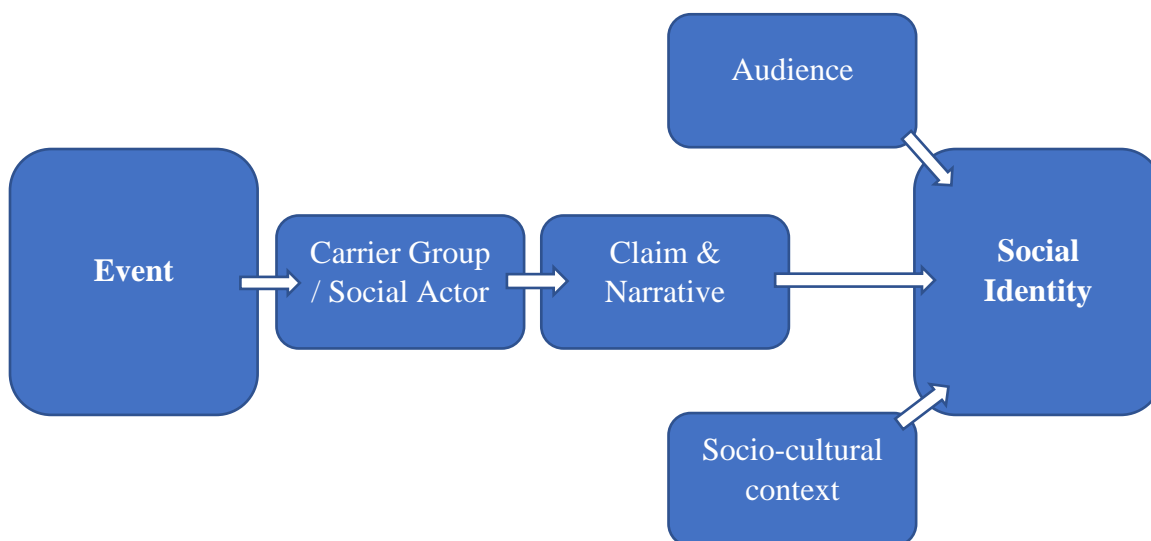
the wider audience to become persuaded that they, too, have become traumatized by an experience or an event, the carrier group needs to engage in successful meaning work. (Alexander, 2004, p. 12)

Creating a new master narrative is not an easy process, even if all four needed elements are easily identifiable. Social groups are not monolithic and there may be various interpretations about the articulated elements that social actors use to suggest a new master narrative.

The third construct is having an identified audience. The first audience to hear a claim may be other members of the carrier group. Once the social group has accepted the claim, it can then be broadened to include the public. Alexander asserts that, “Only if the victims are represented in terms of valued qualities shared by the larger collective identity will the audience be able to symbolically participate in the experience of the originating trauma” (2004, p. 14). For a larger social group to shape a social identity around the trauma of a victimized group they must desire to care for and support the initially victimized group.

Finally, all of this must happen within a specific socio-cultural context, what Alexander calls “institutional arenas.” The contexts in which claims are made and heard in affect how they are made, how they are received, how they are interpreted, and how they are acted upon. While Alexander identifies a number of contexts that can influence claims, two that are particularly helpful for this research are religion and mass media.

Figure 2. *The Spiral of Signification and Creating a Collective Narrative of Trauma*



Alexander notes that when the spiral of signification happens within a religious context people will often turn to questions of theodicy in the process of meaning and identity making. Questions focusing on why a traumatic event happened often focus on why God would allow suffering. Alexander notes that “the answers to such questions will generate searching discussions about whether and how human being strayed from divinely inspired ethics or sacred law...” (Alexander, 2004, p. 15). When the spiral of signification happens within a religious context it can contribute to how a person views themselves or others in relation to God, a religious identity. When this happens within religious social spaces, such as churches, it can contribute to a religio-social identity that takes into account the ways that individuals relate, or are perceived to relate, to God; but it can also inform how others perceive them and how others interact with them in social spaces.

Examining the media context that spirals of signification happen within calls for analysis of the influences and limitations of mass media. Mass media is presented to the

public with certain assumptions and goals that must be identified in order to effectively understand how it acts as a medium for social actors. Media actors can dramatize or downplay events depending on the ways that they understand them or in line with their aims. For example, News sources may dramatize an event if they hope that it will bring in more readership. The media is also a social institution with political power, thus if a traumatic event is publicized named perpetrators may retaliate against the media. Given the power dynamics at play the media can either be a source of countermemory, bringing forward the experiences of marginalized groups who are experiencing trauma or it can act to reinforce hegemonic narratives.

Through the spiral of signification carrier and social groups construct and reconstruct social identities. Alexander explains this,

“Experiencing trauma” can be understood as a sociological process that defines a painful injury to the collectivity, establishes the victim, attributes responsibility, and distributes the ideal and material consequences. Insofar as traumas are so experienced, and thus imagined and represented, the collective identity will become significantly revised. This identity revision means that there will be a searching re-remembering of the collective past, for memory is not only social and fluid but deeply connected to the contemporary sense of the self. Identities are continuously constructed and secured not only by facing the present and future but also by reconstructing the collectivity’s earlier life. (2004, p. 22)

Thus, memory becomes an important part of understanding how social groups construct identity in the face of and around social experiences. This expands on Halbwachs and Townes who also understand memory and identity reciprocally informing each other sociologically.

Methods Utilized in this Study

This study is a secondary analysis of in-depth qualitative interviews collected by researchers at the Rollins School of Public Health, Emory University as part of the

Training and Empowering African American Churches on HIV and AIDS (TEACH) study. TEACH, a 3 year randomized controlled trial funded by the Agency for Healthcare Research and Quality, aimed to build on previous research by training 20 churches in the Atlanta, GA metropolitan area to implement the *P4 for Women* HIV education program in their churches (Wingood et al., 2013; Wingood et al., 2011). TEACH was approved by the Emory University Institutional Review Board.

Selection of Participants

Interview participants were church leaders and members of 20 predominantly African American churches in the five counties in the Atlanta, GA metropolitan area that had the highest prevalence of HIV. Consent and commitment from pastors to participate in the study for one year was also needed. While not required to participate in TEACH, church leaders and members who would serve as program leaders and facilitators were invited to voluntarily participate in interviews to collect qualitative data.

Qualitative Data Collection Methods

Data for this study came from one-on-one semi-structured interviews with 93 church leaders and members who volunteered to participate in a qualitative component to the TEACH study from 2013 – 2016. Participants chose the location of their interviews and many took place in their church, at the Rollins School of Public Health, Emory University, or in public locations such as coffee shops. The interviews were conducted before participants had received training about or to facilitate the *P4 for Women* program. Interviews were conducted by study staff and graduate research assistants between the ages of 22-55. Interviews were audio recorded for later transcription and included

sections on: the TEACH program; the church’s health education programing; sexual and reproductive health in churches; stigma; and upbringing, which included questions on memories of the HIV and AIDS epidemics.

Analysis of Qualitative Interviews

Interviews were transcribed verbatim and grounded theory guided data analysis. Diverse teams of 3-4 coders utilized an inductive codebook for data coding and codes with a Cohen’s kappa <0.8 were coded to agreement. Thematic codes utilized in this analysis (Table 1) included: Down Low Men, Evolution of the AIDS Epidemic, Homosexuality, and Persons Affected by HIV. A Text query for the name “Magic Johnson” was also utilized.

Table 1. Codes Utilized in Analysis

Code Name	Code Definition	Example
Down Low Men	Men who have secret sex with men, but publicly identify as heterosexual and have sex with women.	“I believe as my community being as African American, I believe that that the women are more affected because of the men and the double lifestyle they live and don’t want to admit that they are homosexual men and still coming home to their wives or girlfriends and transmitting the virus.”
Evolution of the AIDS Epidemic	Perception of how HIV has changed from the 1980s through the present.	“People just think of AIDS as a death sentence, whereas now it is more of a chronic condition.”
Homosexuality	Any discussion of, opinions of, and beliefs on non-heterosexual relationships.	“I don’t understand the attraction of males and males and females and females, but I don’t condemn them. There’s just their own personal preference, and I leave at that.”
Persons Affected by HIV	Who is impacted by HIV	“As African American, I believe that that the women are more affected because of the men and the double lifestyle they live...”

Magic Johnson	Mention of the basketball player Earvin “Magic” Johnson.	“I mean, just what I heard on the television and the main thing was Magic Johnson, but really I didn’t. I didn’t have a HIV test before then”
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Participant Demographics

This study examined interviews from 93 leaders and members of African American churches in and around Atlanta, GA (Table 2). The entire sample were African American Christians. The majority of participants were middle-aged women with the youngest participant being 20 and the oldest being 83. Marital status was similarly distributed across single or never married participants, married participants, and divorced participants, with a small number being widowed. The sample was well educated with 4 in 10 having started or completed graduate school, and about a third of the sample had experience working in healthcare. Most of the sample had been tested for HIV before. Many of the respondents attended large or mega-churches. Demographics for individuals quoted in the subsequent chapters are listed in Appendix A (Figure 5, p. 96).

Table 2. Group Demographic Characteristics of Study Participants

Variable	Total N=93 <i>M (SD) or N (%)</i>
Age	48.2 (12.9)
Gender	
Female	85 (91.4%)
Male	8 (8.6%)
Marital Status	
Single or Never Married	25 (26.9%)
Married	33 (35.5%)
Divorced	29 (31.2%)
Widowed	6 (6.4%)
Education Level	
Graduated High School/GED	4 (4.3%)
Started or Currently Enrolled in College	19 (20.5%)
Completed Associates Degree or Technical School	11 (12.8%)

Graduated College	18 (19.4%)
Started or Completed Masters/PhD	40 (43.0%)
Healthcare Professional	
Yes	33 (35.9%)
No	59 (64.1%)
HIV Tested	
Yes	84 (90.3%)
No	9 (9.7%)
Size of Church Participant Attends	
Medium	11 (11.8%)
Large	32 (34.4%)
Mega-Church	43 (46.2%)
Unknown	7 (7.5%)

Chapter 3: Narratives of HIV and AIDS in African American Churches

This study examined in-depth qualitative interviews from 93 leaders and members from 20 African American Churches in Atlanta, GA. Two narratives inductively emerged in relation to HIV and AIDS, particularly during the 1990-2000s. Participants often described HIV and AIDS as a death sentence that primarily affected white, gay men. One way of learning about the HIV and AIDS epidemics was through Magic Johnson's public disclosure of being HIV positive. Another narrative that emerged described how men on the down low transmit HIV to unsuspecting women. The narratives were not mutually exclusive in their use.

Understandings of HIV and AIDS

HIV and AIDS as a Death Sentence

Like much of US society, African American communities often initially understood HIV and AIDS as a deadly disease that white, gay men contracted. Historical conceptions of HIV and AIDS being related to GBMSM were coupled with perceptions that HIV and AIDS were punishment from God for the sin of MTMSA. Tina described these historical conceptions of HIV and AIDS in relation to her current conceptions,

As an adolescent, it was – it's the ultimate – you gonna die. There's no surviving it. But it's for – gay men get it, and they got it because they was sinful, and that's God's punishment. And we all know this today, that none of that is true. None of that.

Maureen expanded on this historical definition, sharing how her lived experience reinforced, if not co-constructed, her perceptions,

Well, the only things that I remember hearing is that... Well, it's a devastating disease. And, we worked – I worked at the airlines always, you know, since I came out of college – and the airlines, they had a lot of homosexual men that worked with us, so one of them got AIDS and the others got it. And they went

into a panic, 'cause you know, they're very promiscuous... So, you know, one died and then— There's a couple of them that died that was, close, you know – I mean, that I worked closely with.

For these women, and other participants, HIV and AIDS were issues that (mostly white) gay individuals had to deal with. HIV was seen as a death sentence, and in some cases a divine punishment.

Beginning to reflect on the evolution of the HIV and AIDS epidemics, participants often described how they first heard of HIV and AIDS. Some participants noted that HIV and AIDS was not a topic of conversation in their community. Sonya shared, “They didn't actually talk about sexual diseases or, you know, HIV wasn't even heard of back then. Because it was in '80. I didn't know anything about HIV until my cousin, you know, contracted it.” Stigma played a part in the lack of public discussion of HIV and AIDS. Thus, many people who were living with HIV or AIDS would not publicly disclose their HIV status. Tina described that she perceived there to be a low prevalence of people living with HIV or AIDS in her community because of this lack of public disclosure. HIV and AIDS were also collectively referred to by euphemisms, such as “the package” says Carla when they needed to be discussed.

One time that HIV and AIDS became visible to participants was if they knew someone who disclosed that they were living with HIV or AIDS. Seeing a family member living with AIDS was one time that participants learned about HIV and AIDS for the first time or saw it in a way that it became personal for them. As seen above, Sonya learned about HIV when she found out that her cousin was living with HIV. Throughout the interviews many participants disclosed that they had a friend or family member living with HIV or AIDS.

African Americans Can Be Affected Too

Some participants learned about HIV and AIDS when Magic Johnson publicly disclosed his HIV status on November 7, 1991. The announcement initiated conversations about HIV and AIDS in communities that included a broad range of people, including children. Allison was 11 years old in 1991 and remembers how she learned about HIV and AIDS sharing,

I mainly just remember, Magic Johnson, that was like the first me really hearing about it, and then, just really about, you know, multiple partners and blood mixing and that was like, it was like here and there, pieces of information... I think people are becoming more aware, because I think back then, um I mean I was born at '84, but growing up I know that it just wasn't something that was talked about. And then, like I said, the moment people said "man, Magic Johnson got it, like oh, Magic Johnson got it? So everybody can get it?" and, I think that's when people started asking questions

A common sentiment was the realization that African Americans could contract HIV.

Magic Johnson represented a turning point from understanding HIV and AIDS as a white, gay men's disease and illness to something that could affect African American communities as well. Allison also shared,

What do I remember hearing about it? When I found, I think when I first heard about it, it was, was it Magic Johnson? This may sound so crazy. I think when he came out, it like, when it really was like, "Oh this can happen to us?" Kind of thing... And just being afraid, because you didn't know what it was you just knew people died from it. Umm not knowing if somebody, being afraid that if somebody around you had it, you could just easily get it, you know just by being around somebody, so I guess fear was my, when I first heard about it, just really being afraid.

Magic Johnson's Public Disclosure of His HIV Status

No Longer a Death Sentence

Magic Johnson was identified as a notable person within the African American community who was publicly living with HIV. As shown above, participants

remembered when he publicly disclosed his HIV status, particularly as one of their first introductions to HIV and AIDS. Participants who described remembering Magic Johnson's public disclosure also often saw HIV as being able to affect anyone. After drawing on her memory of Magic Johnson, Sabrina described how HIV and AIDS affected African American churches saying,

[Our churches don't talk about sex]... We don't. And, sexual health, sexual behavior and how HIV can affect those in the church. It doesn't exempt you if you go to XYZ church, so- (slight chuckle) it's something that we need to do, so it's very beneficial for the church to have that education. Although it's information out there everywhere, I still believe that a lot of times in our community – when I say our community, I say the black community- we tend to believe that it's a certain group or demographic that's exposed to HIV. And if I'm in church and if I love the Lord, then that won't happen to me ... So, "Well, I'm not gay." You don't have to be. You don't have to be. But someone has slept with someone else that's positive, so. It's because we don't have that conversation about it prior to having sex.

A change came about in African American communities, informed, in part, by Magic Johnson's public disclosure of HIV status. As communities saw Magic Johnson living with HIV, it began to be viewed as a condition that could be lived with rather than a death sentence. Stacey stated,

I just think you look at the lives of people who have been affected by it and previously before we've gotten so much education, and Magic Johnson, you know, and all these big people who, you know, came out and said that, ya know: "I'm living with this disease." Just bottom line. Just people can live a better quality life.

With this, some participants also realized that there was a difference between living with HIV and living an easy life with HIV. Maureen shared,

And then the only other thing I know is, about Magic Johnson. You know, when he got AIDS, and how nobody wanted to... be, you know, they didn't wanna play basketball with him or anything like that. And, then I understand that it got, you know, with medication and stuff like that, that... it wasn't as devastating, you know, disease– that you didn't have to die right away... But you'd have to take medication for the rest of your life.

Following from this, other participants noted that to maintain a medication regimen, individuals would need the finances to afford the required medications. As Sonya stated,

It was scary. I do know that. It was very scary. And it was almost a death sentence. Because they didn't have – the research wasn't as prevalent as it is today. Whereas they got the cocktail kind of, together, where people can take all these different pills to, you know, manage. And then when Magic Johnson came out with it. I mean, and to see him still living and, and I saw him over the weekend with Michigan State for the Final Four game. You know, it brought hope! But people were saying "Well, we don't have the money like he does to get the medications or what is needed to stay healthy." But, I remember, when I first heard of it, it was like a death sentence. If you got that, you were dying.

In fact, some participants described beliefs that Magic Johnson had enough money to buy the things needed to live a healthy life with HIV.

Public Conversations

Perceptions of Magic Johnson's public disclosure on communities talking about HIV varied. Ella felt that Johnson's disclosure opened up space in the community for conversations about the effects of living with HIV. She shared,

But with information again comes power. I think people's mindset, about their history changed, especially since you know you've had Michael- what's his name- yeah, Magic Johnson-who is living with HIV, who is healthy, who is, you know getting the message out there that you know, that this necessarily isn't a death sentence... I think it's more open. I think people realized that it's out there, that people have it and that they can – it is treatable. It is not the death sentence that it used to be.

On the opposite end of the spectrum, Tina did not feel like space had been opened up because Johnson's narrative also informed perceptions that HIV was no longer relevant, because people were seeing Magic Johnson live with HIV for an extended period of time since his initial public disclosure. She shared,

When I started hearing about AIDS and HIV, I was like 10 or 11. It was just comin' out and everybody was in a panic, in a tizzy. Now everybody hears about it and you have, for an example – I know it's probably cliché but Magic Johnson.

He's had it since what, '92? This man is still livin' and looks healthy. So, people have this misconception: oh, obviously it don't exist or I can live through it when you may not have the same services that he have or you may not – your body may be different, you may not survive the same way. So, it's a misconception that oh it's nothing I can do this, when it's very important, you-you need to take it seriously.

Within public discussion that did occur, there was a range of ways in understanding how HIV was occurring within the community and how people are informed about HIV through the media. Pamela stated,

And some people think that it's under control, and some of us know that it's not. So, it's from one extreme to the next. It's either [voice gets high] “oh, no I thought that was under control, you know, think of Magic Johnson” and then you have those like “oh my god it's out of control, did you just see the news last night? They said Atlanta was number 1.”

She saw different conversations happening in her community and she also saw different reactions surrounding public disclosures of HIV status. She continued on sharing,

My experience from talking to people, and this is on a personal level, okay, about the church thing, is when I'm having individual conversations, they're more open to listen to what you have to say. Um, on a group setting, I think that it's either you're gonna get one or the other sides. Especially if you do a testimony type thing, you either gonna get pity where – or you're gonna get judgment. So it depends on the- how you deliver the message and where you're delivering it. You know, if you're doing a testimony it's gonna be “oh, that poor person. Poor you.” But if you're giving – or it's going to be “Mmm, she put herself in that situation.” You know, so it all depends.

Among participants there was an overarching narrative of HIV and AIDS that included or intersected with Magic Johnson's public disclosure of his HIV status. Johnson's disclosure was some participants' introduction to HIV and AIDS and for others prompted conversations about the spread, regulation, and longevity of those living with HIV. Over the course of their narratives, some participants mentioned Johnson in passing. Some utilized memory of him in understanding HIV and AIDS and in constructing a current narrative about how individuals can live with HIV. Others utilized

his narrative while attempting to understand reactions in their community. Most narratives that drew on Johnson's narrative understood HIV as a disease that can be lived with. They attribute a shift in perspective based on movement from HIV and AIDS as a death sentence to the role of prescription drugs in saving peoples' lives, resulting in them living longer. Although, it was also pointed out that Magic Johnson's wealth allowed him access to treatment and medicine that many African Americans could not access due to cost.

Down Low Men Transmitting HIV to African American Women

A reoccurring narrative that participants employed when thinking about the evolution of the HIV and AIDS epidemics, who was affected by HIV and AIDS, and who was in need of HIV and AIDS services within their communities was that men on the down low were responsible for African American women's experiences of acquiring HIV and AIDS.¹⁶ While many participants did not identify how they learned about men on the down low or these men's relationship with HIV and AIDS, Tanisha did share how her and her sister learned about this narrative while they were young:

In the early 2000s, there was the whole down low thing. And men being on the down low. And prisons so. At first we were like, "Make sure your man ain't on the down low, he's going to give you HIV." And things like that. So that was – you know growing up hearing that. So, that was probably what I heard most about when I was younger. 'Course you- in the school system, I think, we talked about it a little bit. My sister did a project on it when she was young. And, um, but that's it. It wasn't a whole lot of stuff we talked about in the school system.

¹⁶ It's important to note here that active voice language that assigns one person or group the act of "giving" or "transmitting" HIV is rejected by the United Nations Joint Programme on HIV/AIDS because it stigmatizes social groups and has led to violence against certain social groups (UNAIDS, 2015). Ideally, language of transmission would only be used to describe individual instances where HIV transmission occurred, and would be specific to contextualize the transmission so as not to implicate an entire social group. Throughout the remainder of this thesis when I describe down low men as "transmitting" HIV it is because this is the narrative that participants told and I need to truthfully describe and analyze their perceptions, but I acknowledge that this language is problematic and harmful.

GBMSM and MTMSA: What is the Linkage?

Some women related or used the terms “gay,” “bisexual,” or “homosexual” to describe men on the down low. Barbra spoke about the need for her church to discuss “gayness” and described men on the down low.

The church is going to have to be able to talk about...gayness. Now I don't know what the statistics are, but I think this has come down in the gay community. So the church needs to talk about people who have not come out...who still may be married and still, whatcha call it, on the down low.

Janice described men on the down low using the word “bisexual” saying, “Well I think you-when you have guys that...were bisexual but they don't let their partner know that they go both ways. So that's what's really scary, to me, right now.” In these interviews participants seemed to ascribe the term “bisexual” to men on the down low. However, “bisexual” is an identity or sexual practice that men can hold or engage in openly or on the down low. So, it seems that these women are conflating the term. The same was also true to some extent with the word “gay,” although this word could also be used to describe men who exclusively engage in sexual relationships with men. Thus, some examples that follow may use the words “bisexual” or “gay” to when describing men on the down low.

Risky Behaviors and Non-Disclosure

Men on the down low were negatively perceived as engaging in risky sexual behaviors.¹⁷ Aliyah shared how her experience working in a pharmacy has informed how she understands MTMSA sexual risk:

¹⁷ One systematic review suggests that African American men on the down low may not actually be engaging in the risky behaviors that participants perceive them to engage in. “If black men on the down-low follow the same general sexual risk pattern as nondisclosing black MSM, black men on the down-low may engage in fewer sexual risks with male partners than black MSM who are open about their sexuality”

I'm not homophobic or anything like that I don't have an issue. But I realize that working at my job that it seems like that more of our patients who come to get HIV medication are homosexual males. So I think it's like increasingly growing in the community... And then – Atlanta period I think has a lot of homosexuals too so I think they might practice higher risk sexual activity than others... I don't know. But it seems like as far as our store it seems like there's a lot more homosexual guys from the time I started working there.

Perceptions of the riskiness of MTMSA were linked to acquisition and transmission of HIV. This is important because while participants perceived GBMSM as transmitting HIV amongst themselves they also perceived men on the down low, as a subpopulation of GBMSM, as transmitting HIV to women.

The most commonly identified behavior associated with the transmission of HIV was down low behavior. Down low behavior is defined as men secretly engaging in MTMSA and not telling a public female partner. For example, when asked who was at risk for acquiring HIV, Erica expressed this saying that women are at risk, “because there's so many bisexual relationships. There's so many people that won't deal with their sexuality and they bring other people into it, and there's so much partner switching going on.” Similarly, Veronica shared that MTMSA is ontologically risky saying,

I think it's more young adults, and gay and lesbians. I think I'll say more of gay, be more impacted by it, because they are sexual preference. Not that I'm against their lifestyle, but I think they need to be made more aware of the safety being engaged in that type of sexual activity, so I think it's more of the age group from eighteen, from seventeen now, seventeen to about thirty-five, and based off their lifestyle.

(Millett et al., 2005, p. 55S). While the review does not indicate that African American GBMSM do not engage in risky sexual behaviors, it does suggest that placing an overarching narrative of ontological risk on African American men on the down low who engage in MTMSA may not be empirically founded.

The perceived risk of engaging in MTMSA was linked with participants believing that African American women are acquiring HIV from their male partners who are on the down low. Monica explained this saying,

[HIV is] so connected with um with being gay or bisexual and people think to forgive that. Especially with women and women of color those stats are rising higher and higher each and every day and it's not that we are getting it by ourselves, we're getting it because we are being infected by somebody else.

Who in Your Community is Most Affected by HIV and AIDS?

For these church women, the subpopulation most commonly identified as being greatly or most affected by HIV and AIDS was African American women.¹⁸ Dorothy shared a common perception saying,

I really didn't think much about it, I knew that it was an issue especially with older black females and I knew that like many other health issues that we're uh proportionately affected greater than any other population when it comes to these type of diseases.

Some participants also described reasons why they believed that African American women are the most affected. A common justification was that statistics supported this belief. Debra made an appeal to statistics in her interview saying,

Debra: It's prevalent you know and it's very - and I know how high it is in our community and I know how it's killing black women; we get it quicker, you know than a man does, and you know it does a number.

Interviewer: So would you say black women are affected the most?

Debra: That's what the stats say.

While participants were predominantly women, some of the few male participants in this study also shared the belief that statistics showed that African American women are the

¹⁸ While participants most commonly identified African American women as being the most affected by HIV and AIDS, some participants also identified other groups including: young people, senior citizens, drug users, and anyone who was sexually active.

subpopulation most affected by HIV. For example when asked who was the most affected by HIV, Wayne shared, “I fell the African American – Statistics I think show African American females, so I would say you know African American females and males, but I think it’s a little higher rate of females.”

Personal experience was also a source of belief that African American women are the subpopulation most affected by HIV and AIDS. Glenda described how her experience working in health care informed her perception that women were the most affected by HIV and AIDS saying,

I guess just from seeing the type of patients that I see and knowing what their diagnosis is. With HIV, it’s more so the female population. And that’s from working in a hospital. I know that sometimes...I thought it would be opposite, but I’ve actually seen it (laughs) so I guess it’s different.

Men on the Down Low and Women as Most Affected by HIV

The narrative of men on the down low transmitting HIV to women was linked to participants’ perceptions that African American women are the subpopulation most affected by HIV and AIDS. Katrina displayed how these two perceptions are woven together when she summarized the narrative of how men on the down low “give” African American women saying, “I feel like women are most affected by HIV. Because we usually get the short end of the stick because some mean are bisexual and undercover and all that.” The narrative described how HIV and AIDS went from being a white, gay man’s disease to spreading among African American men, particularly those on the down low. These men were seen as engaging in sexual behaviors (MTMSA) that put them at risk for acquiring HIV.¹⁹ Because these men are not public about their sexual activity or

¹⁹ Millett et al. (2005) complicates this assumption and indicates that the perception may not be empirically based, and at minimum needs further research.

history they are seen to transmit HIV to their female partners, who are unaware of the men's HIV status. Thus, African American women are seen as particularly vulnerable to acquiring HIV. Retelling of this narrative within African American communities may have contributed to misconceptions that African American women are the subpopulation most affected by HIV, although this may have also been influenced by misinterpreting statistics, as these were often cited. Overall the narrative holds African American men on the down low responsible for African American women's experiences with HIV and AIDS.

Acceptable and Unacceptable HIV Acquisition

Barbra described how the narrative of men on the down low is linked with religious life in African American communities. She addressed both the influence of the institutional church and the Bible as an authoritative source of meaning making.

Describing how religion constructs acceptable and unacceptable ways of acquiring HIV she shared,

I think that the church has gotten a little silent on it because when the breakthrough, and drugs, and all of that wasn't there, the church could say "Oh my God! People just dying, just dying!" You know, we got in this crisis mode. Now the people are living, and the church is not comfortable with how you got it in the first place. It's almost like it's the good HIV/AIDS and it's the bad HIV/AIDS. I think we're gonna find two separate camp. ... but if you got it from a blood transfusion, or your husband gave it to you and you didn't know he had – was sleeping with a man or something like that. That's the good part. Now this part over here. You got it because you are living the wrong lifestyle. God didn't intend, you know, hell and damnation over here.

Barbra described how women who "get" HIV from men on the down low have acquired HIV in an acceptable way. Yet, those who acquire HIV when they are living the "wrong lifestyle" have gotten HIV in an unacceptable way. More attention about what constitutes a "wrong lifestyle" will be given in the next section. Barbra also shared her own

experience learning about the down low from Oprah and questioning whether her male relative was on the down low and/or living with HIV and/or AIDS.

So, the church needs to talk about people who have not come out...who still may be married and still, whatcha call it, on the down low. Because one of my cousins asked me a few years ago, she was like “My sister and I, we heard some rumors about our brother,” and we were asking each other, “what is the down low?” And I was like “Since Oprah did the show on it, doesn’t everybody know?” So, I think, and even – I mean even with the family. Even after an African American family like mine, even after a couple of people died with AIDS, the family still didn’t wanna talk about it. It’s still this little secret thing. I went three – maybe four years ago to a cousin’s death. And I remember my sister-in-law saying she saw him in the doctor’s office in South Carolina and his mother would say “No, he’s on his way back to Baltimore.” So for years, [he] had AIDS, and...died. And we were at his funeral, and nobody wanted to – I haven’t even told my 86 year-old aunt. So it’s still, you know this—and he was married with and had a family...two children, wife, married for years. But he had AIDS, and I think the medicine kept him alive a long time ‘cause he died at 65.

MTMSA and Homosexuality in African American Churches

Church Dogma, MTMSA, and GBMSM

Broadly, MTMSA and homosexuality are seen as sinful in African American churches, including by participants in this study. This forms the context in which religious identity formation takes place. Central to this is the authority of the Bible in African American churches. Tanisha shared how her church understands the Bible saying,

You know, we’re a Bible-based church. So, we base our faith specifically on what the Word of God says. So, we don’t want to condone it, but we also don’t want to play judge. So, of course, if that topic comes up, of course our pastor has to say that it’s wrong, but he’s also said that there’s grace, just like with me and my mess-ups.

For her church, the Bible informs how MTMSA and homosexuality are understood and dictates that the church cannot support it. Debra shared that her views of MTMSA and homosexuality are also based on biblical authority, noting how her church pushes back

against what she understands as broader socio-cultural discussions of MTMSA and homosexuality saying,

I don't know, you can call me homophobic but I'm fully with the Bible teaching about homosexuality. I do not feel like you're born that way... it is learned behavior that they're trying to portray now that you were born gay... I don't feel that way.

Debra rejected colloquial discussions that portray individuals as being born ontologically gay or with same-sex desires. Allison also shared on this, describing how the Bible informs how her church responds to GBMSM.

Well of course, like I said you love the person, but you know that what they are doing is not, it's not according to the word of God, it's sin, so love 'em, pray for 'em, and educate 'em; definitely on what the Bible says about it. But their choice is their choice, but just love 'em and embrace 'em where they are; and pray that they once again come into the knowledge of truth, or are willing to conform to what the word of God says, cause' we, we have people that had practiced that lifestyle and are no longer.

Janice also demonstrated that there are different ways to read the Bible, or at least brings it to the forefront when thinking about GBMSM saying, "You have to love everybody, that's what the Bible teaches. You have to love everybody, you treat everybody the same, you know."

Discordance Between Dogma and Perceptions

An emerging trend was for participants to describe themselves as being more accepting of GBMSM than their church was as a whole. For example, Ashley displayed this sharing,

Interviewer: Yeah. Um, what's your personal opinion about homosexuality?

Ashley: Personal opinion... we just had some discussion about this on yesterday's Bible study. So personally I don't have a problem with it. I have friends, I- yeah, personally- and it's different from quite a bit of religion and religious beliefs and the church's beliefs, so.

Interviewer: Um, so it sounds like your church is not huge on homosexuality? Let's put it that way.

Ashley: Yeah. *[Laughter]* ...

Interviewer: If someone came out as gay in your church how do you think they'd be viewed or treated?

Ashley: Hmm... *[Sigh]* I'm not sure. I mean, based on... I feel like based on some of the conversations that have been had about certain scripture, I feel like it wouldn't be... welcomed. Like, I feel like there are some members that... *[sigh]* and I'm thinking about youth in particular where, you know, it's *[sigh]*... it's one of those things that... I feel like they would not be like, "Oh, you can't be in this church anymore," but that there would probably be a sense of, "Okay, let's try to help this person get out of this particular sin in some way and let's work with them." That'll be kind of, somewhat of a goal, and I don't necessarily agree with that, so.

Church Leadership and GBMSM

While some participants perceived their churches as open to GBMSM, no participants thought their churches would accept a GBMSM pastor or church leader.

Desiree described the negative outcomes for both lay members and church leaders, noting the much harsher negative outcomes for church leaders, saying,

If it was just a member, I don't think that it would be as bad as it would if it was someone that was a leader, 'cause I'm quite sure that the members of the church would ask for that person to step down and do all these type of things and all that. But just the regular member just coming out and saying it, I believe people will- of course they'll have their naysayers and negative comments on it, but at the end of the day, I think they will more so embrace it with love and just tell that person, "Oh, I'm going to pray for you,"

Aletta shared a new perception on why it was not acceptable for leaders to engage in

MTMSA or identify as GBMSM.

I think as long as they're not in a leadership position, then it's acceptable. I think if someone made that kinda information known in my church who was in a leadership position, I think that people would think differently. I think that would be a challenge within my church, quite honestly. Because I think that people who have children would have some concerns about their children being around people who are in a leadership position who do openly express that kind of lifestyle.

Her perception of how a GBMSM church leader would be received was not explicitly

based on the Bible, although that may very well have informed it, but rather appears to be

based on harmful stereotypes that GBMSM will acculturate children into a GBMSM lifestyle or that “GBMSM” is synonymous with “pedophile.”

Perceptions of GBMSM: A Generational Gap

Some participants noted that there was a generational gap in how GBMSM are perceived in the church and that younger people were likely to be open to GBMSM in the congregation, which may follow national trends. Albert shared,

That’s a very good question. By some [GBMSM] would definitely be judged. And what I mean by that, I mean shunned – and I hate to say it – talked about, that kind of thing. By others, and especially again our younger- our younger congregants, I think they’d be openly embraced, accepted, no judgment. I’ve even had similar conversations with my children, you know, and they don’t understand fully the position that I take, so I think our younger congregants would be loving and acceptable. But regardless, as a [church name] ministry, we try to accept everyone just as they are, just as Christ accepted all of us as we were when we came to salvation.

The Place of GBMSM in the Black Church

As Albert mentioned, shunning GBMSM has been a practice of African American churches because of the unacceptability of MTMSA. LaTasha also shared that her church might shun GBMSM people initially after they come out.

Maybe... shunned against for a little while, I think. Initially, just because of the preachings and teachings of man is meant to be with woman. So... I think that would happen, maybe initially. And it might take people some warming up to- to come around to.

Yet not all churches do this, an emerging theme was the need for participants to state that their church does not shun GBMSM. Latrice shared that while someone coming out as GBMSM would be a shock, they would still be welcome in the church, sharing, “I think it would probably just be if it was something that nobody knew anything about, it would be maybe shocking. But they wouldn’t, again, they wouldn’t turn them away or shun them about it or anything like that.” Rene also shared,

They're not for that. BUT, they will not shun them or whatever. We would tell them "Come on in!" And love them and treat them the same way. But we would tell them what the Bible says, and we will give our views on it, but we will not tell them, "Oh you can't come to [church name] because you like women or cause you like men." We wouldn't tell them that.

As Rene alluded to, there was a general sense that GBMSM should not be shunned from churches because this precluded them from being evangelized to or converted from MTMSA to more acceptable sexual behavior. Ashley described this saying,

I feel like based on some of the conversations that have been had about certain scripture – I feel like it wouldn't be... welcomed. Like I feel like there are some members that... [*sigh*] and I'm thinking about youth in particular where, you know, it's [*sigh*]... it's one of those things that... I feel like they would not be like, "Oh, you can't be in this church anymore," but that there would probably be a sense of, "Okay, let's try to help this person get out of this particular sin in some way and let's work with them." That'll be kind of, you know, somewhat of a goal, and I don't necessarily agree with that, so.

Mae went into more detail about the process that bringing GBMSM into the church and converting them to acceptable sexual practices would look like. She also described GBMSM in a way that suggested that they did not, at least fully, understand what it meant to be a Christian, indicating that at least part of Christian identity in her church is based on sexual ethics.

Just like anybody else, we didn't condemn them, or stand them out, or whatever. They became part of a connection group. The connection group leader worked with them, they would come to the meetings, connection group meetings, pray with them, encourage them, because they gave their life to the Lord. We have what we call "encounters" that, I guess you could call it like a deliverance thing, that we have like every 3 months where we have it for men, women, youth; where you have 3 days that we get before God and we deal with every aspect of our lives from unforgiveness, sexuality, low self-esteem, guilt, all different things, every aspect of it. And we give the – we tell what God, what the word of God say, we pray over them, we have to explain to them about generational curses, what sin is, and all of that. And then a lot of them get delivered that way. Then we walk with them as they learn to walk. Teach them how to have devotions, teach them how to seek the Lord, hear from God themselves. How to read the Bible daily. How to

begin their day acknowledging God in what they do and allowing Him to lead and direct them.

An important part of understanding how participants understood their relationship with GBMSM is that they embraced what has colloquially been referred to as the “love the sinner, hate the sin” approach. This means they perceived that they can love GBMSM without having to challenge them on their sexual identity, while still being able to challenge them on their sexual behavior (MTMSA).

Identifying GBMSM in African American Churches

The final point suggests GBMSM exhibit certain behavioral mannerisms and are therefore easily identifiable within African American churches. This theme is particularly interesting given that men on the down low are not (supposed to be) publicly identifiable. Debra utilized cultural stereotypes to identify GBMSM in her church, sharing,

They ain't gotta be open honey. It's the way they move and talk, and you know... But I don't know whether they're open with it... cause they certainly have not come out with it to me, but you know, you can see it.

Monica shared that she doesn't think that GBMSM members who are publicly identifiable are treated differently than other members:

I don't think we would react any differently because they're – they have that relationship based on what's already been established with time so it might shock some and some might think well it's about time you know addressed it or dealt with it you know what people think of us, they already know.

Monica brings up that some people may be shocked if a GBMSM person publicly discloses their sexuality, which may be an insight into how men on the down low are received by churches if they decide to disclose their MTMSA or their behavior is publicly found out through another means.

Overall, churches' understandings of GBMSM and MTMSA are founded on and constructed using biblical passages that indicate homosexual activity is sinful. The Bible is seen as a source of authority for understanding GBMSM identity/activity. The Bible is used as both a source for embodiment of "love the sinner, hate the sin" mentalities and pushes to convert GBMSM to heterosexuality. Some participants described their opinions on homosexuality to be more accepting than those of their church as a whole, but also often still thought of homosexuality as an "issue" or a sin to be overcome.

It is important to note that while these views apply to all members of the church and its leadership, leadership are held to a higher standard than regular members and could lose their leadership position if they were publicly identified as GBMSM, which may point to the seriousness with which churches look down on GBMSM. It also appears that churches feel that GBMSM should be easily identifiable so that they can be brought to understand the error of their ways.

Summary of Results

Some participants reflected on the ways that public discourses around HIV and AIDS have shifted and become more visible since the 1980s. Many participants who described this also acknowledged the ways that their personal understandings of HIV and AIDS have shifted over time. Many participants described learning about HIV and AIDS by seeing people living with the virus and/or disease. Another common narrative was when participants learned about HIV and AIDS after Magic Johnson's public disclosure of his HIV status.

For participants who discussed Magic Johnson, his disclosure of HIV status often helped them understand that HIV was not only a white, gay man's disease, but could also

affect African American communities and churches. It also helped communities understand that HIV was not a “death sentence” that would inevitably lead to AIDS; this was recognized to be due, in large part, to the fact that Magic Johnson was wealthy and could afford medical care and treatment.

Another narrative that emerged was of how men on the down low transmit HIV to African American women. Participants suggested that men on the down low engage in risky sexual activities that make them prone to acquiring HIV. Because these men are not open about their sexual activity to their female partners, they end up transmitting the virus to their partners. Thus, participants perceived African American women to be vulnerable to acquiring HIV, which appears to be linked with (mis)perceptions that African American women are the population most affected by HIV. Women acquiring HIV from men on the down low was identified as an acceptable way to acquire HIV, while men acquiring HIV due to engaging in MTMSA was identified as an unacceptable way to acquire HIV.

Broadly speaking, participants cited the bible when discussing why they or their church see MTMSA to be sinful. Participants almost exclusively saw MTMSA as a sin. Not all participants explicitly rejected GBMSM, even if their church did, but these participants frequently described a “love the sinner, hate the sin” mentality, described MTMSA as an “issue” to be dealt with, or said that they don’t reject GBMSM because everyone sins. Some participants described how their churches seek to convert openly GBMSM to heterosexual identity and/or activity. Finally, participants described the ways that they use social cues (read: stereotypes) to identify GBMSM in their churches, with some indicating that there were no GBMSM in their church and others saying that they

could identify them based on their movement or speech without them needing to be open about their sexuality.

Chapter 4: The Spiral of Signification of HIV and AIDS in African American Churches

African American women are disproportionately affected by HIV and AIDS. While they are not the most affected Black subpopulation, their interpretations of how HIV transmission occurs are significant and important. I know turn to how African American women utilize religion to collectively make meaning of their experiences with HIV and AIDS and build social identity from the definitions that they assign to HIV and AIDS.

This chapter will be an application of Alexander's (2004) theory of signification (Figure 2, p. 30) to the narratives presented in the previous chapter. The theory posits that for an event or narrative to be taken up by a group as a means of forming social identity, the carrier group or social actors, narrating the event need to identify the nature of the pain and the victims, relate these to a wider audience, and finally identify the person or group responsible for the pain/trauma. This all takes place within specific socio-cultural contexts, including religious contexts like churches; it is also informed by the ways that social actors or the media present the narrative.

Examining Magic Johnson's Public Disclosure of His HIV Status as a Spiral of Signification

Magic Johnson emerged as an important figure within participants' memories and interpretations of HIV and AIDS. Yet, he was often used as a reference point, rather than an actor in a full narrative. While the narrative of Magic Johnson's public disclosure meets some of the constructs of Alexander's theory it does not meet all of his defined constructs. Yet, this may not mean that is cannot be used to construct a new master

narrative that is used in social identity formation. Discounting the narrative as unimportant in how African American women understand HIV and AIDS is not a useful approach. It is necessary to take a nuanced approach while examining where the narrative does and does not fit constructs of the theory and think about the ways that this could inform understandings of HIV and AIDS in African American communities.

Articulating the Pain of the Event

The first constructs of Alexander's theory of signification is the event itself. In the narratives that participants shared, it is difficult to find the event in question. Is the traumatic event Magic Johnson's acquisition of HIV, his experience testing positive for HIV, his public disclosure of his HIV status, or the public being forced to reckon with the fact that HIV and AIDS are not isolated within society, happening only in GBMSM communities? No participants mentioned the event of Magic Johnson acquiring HIV, an event he himself did not even know was happening, nor did they describe his experience testing positive for HIV, although he did write about this (Johnson, 1991). His public disclosure may seem to be the event in question, but it was never discussed in detail, study participants only indicated that it had happened. Alexander's theory dictates that the narrative must articulate the pain of the event, which points to the event in question being African American communities realizing that a man could acquire HIV through heterosexual activity. Yet, while some participants described this realization, making this a reasonable conclusion, more participants focused on Magic Johnson's experience as a source of hope, rather than describing it as a painful event. This may be nuanced because hope is often a response to pain, but such linkages were not made by participants in these interviews. Many participants focused on how Magic Johnson is able to live a healthy life

with HIV, rather than focusing on emotional pain that could come with learning one's HIV positive status. This suggests that references to Magic Johnson do not fit within Alexander's theory. Although they might fit well in another theory that examines how hope aids in the construction of a social identity.

Identifying the Victims and Social Actors

The second constructs to examine are the social actor, carrier groups, and victim(s) of the narrative. Magic Johnson himself is the first social actor. Learning his HIV status in privacy allowed him the opportunity to have emotional experiences in relation to the revelation and to construct the narrative that he wished to present to the public. With respect to the nature of the victim in this narrative, the majority of participants did not describe Magic Johnson as a victim, but as a role model for how to live with HIV. This may have been due, in part, to how Magic Johnson constructed the narrative that he wanted the public to hear. In writing about his public disclosure for the magazine *Sports Illustrated* Magic Johnson took time to note that the incidence of HIV among heterosexual men was increasing and that he would work to make this more known (Johnson, 1991). He did not describe himself as a victim when he told his story to others but focused on how he could live a healthy life with HIV and educate other heterosexual African American men about HIV and AIDS.

In addition to this, some participants still saw Magic Johnson as living a life of privilege. They acknowledged that being diagnosed with HIV or AIDS can be painful and traumatic experiences. Yet they also noted that without the correct medication living with HIV can lead to AIDS, which is serious and can lead to death if untreated. But, they also described how Magic Johnson had enough wealth to keep himself healthy in ways that

African Americans experiencing low socio-economic status could not do.²⁰ In this Magic Johnson's narrative breaks from Alexander's theory because the narrative does not fully articulate the pain of the victim because Magic Johnson worked to articulate his hope and commitment to the future, although he may have experienced pain out of the public view. Additionally, participants did not explicitly articulate perceptions of Magic Johnson's pain either, which may give insight into how they utilize his narrative when constructing an identity of hope in relation to HIV.

Relating the Narrative to Its Audience

The first two sets of constructs closely tie to the third constructs: identifying the audience that will receive the narrative and determining how the narrative is relatable to them. In this case rather than many others, I am primarily examining the voices of the audience rather than the voice of Magic Johnson as the victim/social actor. This may also reflect how Magic Johnson was effective in making his story relatable to his target audience(s). Broadly it appears that Magic Johnson hoped to reach as many people as he could, independent of race or gender, but he may have also been speaking particularly to heterosexual African American men like himself (Johnson, 1991; Stevenson, 1991). This study suggests that he succeeded in making his story relatable to African American communities because study participants referenced his story, even though not all expanded on it, by explaining how it shaped their thinking. It also appears that his main messages were that anyone could acquire HIV and that it is possible to live a healthy life with HIV. These messages were received by his target audience whose attitudes towards HIV and AIDS were shaped and changed by them. Consequently, participants who

²⁰ This is a prime example of socio-economic status as a social determinant of health.

referenced Magic Johnson often did so noting that they felt that anyone, including themselves, could acquire HIV.

One phenomenon that provides external evidence of this was seen in the wake of Magic Johnson's public disclosure. HIV information hotlines and testing sites saw large increases in calls and visits immediately after Johnson's announcement, particularly from heterosexual men who did not inject drugs (Casey et al., 2003; Cohn, Miller, Yamaguchi, & Douglas, 1992; Kalichman, Russell, Hunter, & Sarwer, 1993). This suggests that African American men were greatly impacted by Johnson's public disclosure and their concern about HIV and AIDS, as well as interest in HIV and AIDS education and testing significantly increased after the disclosure. Yet, some research suggests that this concern and interest was confined to a period of two to three weeks (Kalichman & Hunter, 1992; Kalichman et al., 1993). W. J. Brown and Basil (1995) add nuance to the conversation about how Johnson's public disclosure affected the nation, reporting that individuals who expressed an emotional connection to Johnson were more concerned about HIV and AIDS among heterosexuals and had greater intention to reduce high-risk sexual behaviors. Those with knowledge of Johnson, but no emotional connection to him, did not display these same concerns or intentions.

All of this provides evidence that Magic Johnson's narrative was relatable to his audience. Participant interviews suggest that African American women took up his messages and public health literature suggests that African American men did as well. The messages appear to be relatable because Magic Johnson broadened notions of who could acquire HIV to include his audience. His message that it was possible to live a healthy life with HIV also appears to have made his narrative relatable because it gave

people hope. This is the construct of Alexander's theory that Magic Johnson's narrative fits into the most neatly.²¹

How Context Informs Responsibility

The final constructs to examine are the social context for the narrative and assignment of responsibility for trauma or pain. The social context and transmission of the narrative took place in the mass media. Part of why this narrative was widely known was because it made for interesting news. The media took up the story and talked about it for an extended period of time because it was something that would bring in viewers. In some ways Magic Johnson was allowed to participate in countermemory²² through media coverage because he was able to televise his public disclosure announcement and was able to publish a piece in *Sports Illustrated*, a major sports magazine (Johnson, 1991).

As such, his disclosure became a practice of countermemory making it more relatable to African American communities. On the other hand, one must consider how preparing to give a public disclosure may have informed how Magic Johnson made the disclosure and addressed responsibility. Magic Johnson steered away from assigning responsibility for his HIV status to anyone other than himself. He made a point to note that he did not know who he had acquired HIV from, nor did he appear overly concerned

²¹ It is also interesting to note that the data here fit into a construct of public health socio-behavioral theory called "cues to action," a stimuli that affects how individuals perceive the threat of disease, either to their own susceptibility to disease or the severity of the disease if they contract it (Sugg Skinner, Tiro, & Chapman, 2015). As discussed, Johnson's public disclosure created a short-term perception of susceptibility to HIV for African American men that prompted them to seek out HIV and AIDS education and testing. Thus while the narrative as a whole may not fit into Alexander's theory to help us understand how African American communities formulate social identities in relation to HIV and AIDS, it may help public health researchers better understand HIV testing behaviors.

²² A memory from a marginalized group that resists and challenges hegemonic memories that function to reinforce marginalization. In this case Magic Johnson's disclosure provided a counter memory against hegemonic narratives that only white, gay men acquired HIV because Johnson is neither white nor gay.

with finding out and assigning them responsibility instead of himself. He accepted responsibility, describing how he had relations with multiple partners without using condoms (Johnson, 1991). Within Alexander's theory, it's difficult to understand how the assignment of self-responsibility works. Yet, because the theory is about social relationships and identity formation it would seem that responsibility and victimhood cannot be assigned to the same person, because there is supposed to be a social relationship between them that can inform how broader social identities are formulated. Magic Johnson's disclosure may have also been more effective in spreading his message of hope because he did not assign anyone other than himself responsibility. Yet, like other constructs, this one again deviates from Alexander's theory.

Summarizing the spiral

The observed references and narrative of Magic Johnson's public disclosure of his HIV status do not fully meet Alexander's theory of signification. As a social actor Magic Johnson crafted a relatable narrative that he would present to the public, but his narrative was not of trauma or pain like Alexander's theory pinpoints. The foundation of Magic Johnson's narrative was one of awareness and hope, which it appears that his narrative successfully infused into African American communities. This may lead to a different kind of social identity formation than Alexander's theory can explain.

Additionally, there is room for further research utilizing Alexander's theory because African American churches and communities often view heterosexual promiscuity as unacceptable sexual behavior, yet participants did not describe this in relation to Magic Johnson. If these beliefs are present and connected to interpretations of Magic Johnson's narrative (although not explicitly described in this study) then there is a

need to further explore and nuance how victim status and responsibility are assigned in this narrative and the nature of the social relationships between the actors assigned these identities. Thus, future research may specifically seek to understand how African American women perceive the nature of Magic Johnson's self-professed promiscuity.

Examining MTMSA and Homosexuality in African American Churches and Narratives of Down Low Men Transmitting HIV to African American Women

A second narrative that emerged in this data was of men on the down low transmitting HIV to African American women. Yet, as the data also suggests, this narrative cannot be examined separately from discussions of MTMSA within African American churches. The narrative of down low men and their relationship to African American women concerning HIV meets all the required constructs of Alexander's theory of signification. As for Alexander's final two constructs, context and assigning responsibility, I argue that the narrative of men on the down low has occurred within a religious context that has informed both the nature of the victim(s) and the agent (or social group) to whom responsibility is assigned.

Articulating the Pain of the Event

In contrast to the narrative of Magic Johnson's public disclosure of his HIV status, the narrative of men on the down low has a clear traumatic event. Participants described how down low men transmit HIV to their female partners. Some participants elaborated on the pain associated with this event. However more in-depth probing during interviews would have yielded more information and been beneficial to this examination.

Some participants remembered how the church used to lament the death caused by AIDS but noted that with the emergence of multidrug therapies this lament has

decreased. With the new status of HIV as a chronic condition, questions of how HIV was acquired have increased. Currently, death is often not an immediate effect of HIV acquisition and there may be less pain caused by a fear of death. Yet, there may still be pain around the taking on a new identity as someone living with a chronic disease and illness. HIV represents both a disease and an illness as P. J. Brown and Closser (2016) define the concepts. Disease describes HIV as a virus that lives in the body and illness describes the social experiences of living with HIV and/or AIDS. Understanding HIV as a chronic illness, or a new lifelong change in social identity and therefore experiencing social interaction from a new social location, can highlight some of the pain that may be experienced.

Looking at HIV as a disease, some of the pain is highlighted when thinking about access to treatment and care. As participants noted when discussing Magic Johnson, getting high quality care for HIV costs money, so it may be useful to further examine the reactions of higher and lower socio-economic African American communities to acquiring HIV. This is particularly important because the CDC estimates that only 54% of African Americans living with diagnosed HIV in 2015 has achieved viral suppression,²³ which allows individuals to live healthy lives with HIV (CDC, 2019).

African Americans in the media have challenged the idea that anyone living with HIV can live a long or healthy life, just like this study's participants pushed back against it. Publishing on an HIV and AIDS blog, Montague (2010) and Terrell (2010)²⁴ both

²³ The CDC states that, "If taken as prescribed, HIV medicine reduces the amount of HIV in the body (viral load) to a very low level, which keeps the immune system working and prevents illness. This is called viral suppression—defined as having less than 200 copies of HIV per milliliter of blood" (CDC, 2018c).

²⁴ Terrell also published the same article with HuffPost (Terrell, 2010). While the articles are the same, for simplicity I only cite the original version within the body of this work.

respond to an episode of *The Oprah Winfrey Show* where Oprah tried to use the narrative of Magic Johnson living with HIV to console her guest, a woman who acquired HIV from her husband, who was on the down low (Oprah, 2010b). Both Montague and Terrell reject Oprah's indication that Magic Johnson is proof that everyone can live a healthy life with HIV. Terrell shares,

The episode's only saving grace was when Bridget [the guest living with HIV] became pissed off at Oprah's use of Magic Johnson as an example of how everyone living with HIV can be healthy and life with HIV can be easy. Bridget jumped in and said, "Let me stop you here. Magic Johnson does not have the same life that an average person [with] the disease. ... Magic Johnson can buy any doctor, any medication in the world. He has people who cook for him. He has people who clean for him. ... people can live with it, but it's not simple like everybody says." (Terrell, 2010)

Montague and Terrell are both African American women and thus the ways that they reject the notion that it is easy to live with HIV because Magic Johnson does, begin to shed light on the ways that an HIV diagnosis is still painful for African American communities, and particularly women.

Another source of pain that comes with this narrative is the discovery that one member of a relationship was not faithful to their partner and may have also put their partner at risk for acquiring HIV. Barbra described how Oprah informed how she understood men on the down low which she applied to viewing a cousin she believed was living with AIDS. Her story highlights some of the perceived deception at play because she notes that it was not confirmed if this cousin was living with HIV and/or AIDS. The stigma of both living with HIV and/or AIDS and of being perceived as being on the down low prevented the family from discussing this with her cousin or with each other. She also highlights the deceptive nature of living on the down low by highlighting that "he was married and had a family... two children, wife, married for years."

Oprah informed how Barbra learned and thought about men on the down low. This is one example of how Oprah, as an African American celebrity, holds a lot of power to shape individual and community perceptions; several participants brought up Oprah as a source that taught them about HIV or men on the down low. In a 2004 episode of *The Oprah Winfrey Show*, titled “A Secret Sex World: Living on the Down Low,” Oprah both shows how painful it can be to discover that a partner is living on the down low while potentially shaping how audiences understand and react to men on the down low (Oprah, 2004). Her website’s description of the episode shares,

Imagine you're in a loving relationship with a man who you think is committed to you. You would probably never think he would have an affair with another woman...let alone promiscuous sex with other men, but that's exactly what some say men who are living on the "down low" are doing. This behavior isn't just harmful to a relationship; it can also be life-threatening to you and your partner.

But Oprah isn’t the only person on this episode to indicate the pain that may be involved in finding out that someone is on the down low. Her guest, J.L. King²⁵ describes his story, particularly how he thought he “had the best of both worlds,” was caught by his wife, and then went through a divorce. King further indicates that the experience is one of pain stating that African American communities’ view his speaking about his experiences as “airing our dirty laundry.” (Oprah, 2004)

An interesting part of King’s story is that he indicated that he would go to African American churches to find potential sexual partners and shared, “I can go anywhere in the country and find out what churches where most of the guys are, where I can make that

²⁵ At the time King identified as heterosexual, although he had been caught engaging in MTMSA on the down low. Currently, King has taken on a homosexual identity stating, “I have accepted the fact that I am a black, gay, proud man. Fear is what kept me on the down low. The fear of losing my family. The fear of losing my children. The fear of hurting my parents. The fear of losing my relationships with cousins and extended family and the church” (Oprah, 2010a).

connection... You're not going to find me in a gay club..." (Oprah, 2004). Whether this is a common practice or not, the dogmatic understandings of MTMSA suggest that finding this out would be painful for church communities, to discover that they had inadvertently aided in something they see as sinful.

Oprah gives another reason that finding out a partner was on the down low and/or living with HIV can be painful when she shared, "This hidden culture of men living a dangerous lie has ruined so many lives. It's broken up families and put so many women at risk" (Oprah, 2010b). Finding out that a partner has been living on the down low can cause families to split apart at times when family support may be needed the most. Family is an important part of African American communities and culture and having your family and support system break apart when you may be facing a HIV diagnosis can also cause pain.

While many participants did not describe the pain of being diagnosed with HIV or the pain of finding out that their partner was on the down low, there is still pain in this experience. One limitation of this study may be that no participants had personally experienced acquiring HIV from a partner on the down or if they had, the events were too painful for them to share in these interviews. The event of HIV transmission is a concern in African American communities, particularly when it is coupled with finding out that a partner has been living on the down low. And, while some participants named Magic Johnson as an example of someone living with HIV, others noted that he has the wealth to be able to access the resources he needs. The latter opinion was also reflected in Montague's (2010) and Terrell's (2010) blog posts and corroborated by information from the CDC. Some participants who have family members living with HIV also expressed

the pain that they felt when their family member was suffering or dying from AIDS. Debra highlighted some of the pain that is still felt when thinking about HIV within African American communities stating that “[HIV is] killing black women.”

Identifying the Victims and Social Actors

After identifying the event and examining the nature of the pain involved the next set of constructs that Alexander posits are to identify who are the social actors and victims of the pain. In contrast to Magic Johnson’s story, the narrative of men on the down low presented in this research articulates a clear victim: African American women.

African American women were consistently described as victims within this narrative. Women were perceived to be at risk because men on the down low engaged in risky sexual behaviors in secret and then exposed women to HIV. This was also linked with the (mis)perception that African American women are the social group most affected by HIV. Many participants felt that women were the most affected social group, and some explicitly linked this to men being on the down low, but epidemiological data also shows that African American women are not the social group most affected by HIV (Figure 1, p. 7). Returning to the results section, Katrina articulated this belief saying, “I feel like women are most affected by HIV. Because we usually get the short end of the stick because some men are bisexual and undercover and all that.” She believes that African American women are the most affected because they get HIV from men that are “bisexual and undercover.” This ultimately signals that participants do not believe that women are active participants in the transmission of HIV, but instead acquire it from men without knowing that they are “[getting] the short end of the stick.”

African American women are broadly social actors in relation to this narrative, sharing the story with other, particularly other African American women as a warning. One African American woman in particular emerged as a particularly powerful social actor in telling this narrative to wider audiences: Oprah Winfrey. Several participants mentioned that they learned of HIV and/or men on the down low from watching *The Oprah Winfrey Show*. As well, Oprah has hosted several shows on the topic where she described women as innocent victims of men who are on the down low and participating in risky sexual behaviors. Oprah's website offers the following description about a show she hosted in 2004 on the topic,

This behavior isn't just harmful to a relationship; it can also be life-threatening to you and your partner. In 2004, AIDS was a leading cause of death for African-Americans ages 25 to 44. "That is startling," Oprah says. "All of my alarms went off." Women, college students and people over the age of 50 are at greater risk than ever before, and as Oprah discovers, men living on the down low may be one reason why. (Oprah, 2004)

In this show, Oprah offers her interpretation of the phenomenon of men on the down low, describing men as a reason that African American women experience HIV, without identifying any other reasons why. In doing so, she sets up women as passive victims of men on the down low. Six years later, Oprah brought the topic to the media again with an episode where she interviewed a woman who was suing her husband for transmitting HIV to her. Oprah described the phenomenon saying that the culture of men engaging in MTMSA on the down low is dangerous and has put many women at risk for acquiring HIV (Oprah, 2010b). Here she more clearly sets up women as victims of men on the down low. She describes how women are put at risk and how their lives have been ruined because of the deceptive nature of down low behavior.

Oprah may not be the only social actor forming or sharing this narrative, but she did emerge as a prominent actor for the women in this study. Part of this may be because Oprah was already a prominent female figure in African American culture, she didn't have to work hard to get people to listen to the narrative she was sharing – she just had to tell it. Additionally, because she is also an African American woman, she may have been able to articulate the story passionately and in a way that related it to the victims of the narrative – other African American women.

Relating the Narrative to Its Audience

African American women were the target audience who were shaped and believed this narrative. Several participants freely brought up the narrative, providing inductive evidence that the narrative has taken hold in the community and articulated the belief that African American women were to social group most affected by HIV. This is further evidence that the target audience assumed the narrative about men on the down low.

The ability of a narrative to be relatable to an audience is contingent on it articulating the pain of the experience and identifying the victims. As has been discussed, this narrative does both of these things. There are several types of pain that can be experienced by women whose partners were on the down low which clearly identify these women as victims within the narrative.

Finally, having an African American woman, who could be a victim in the narrative framework, as a social actor telling the story helped make it relatable to a wider audience. Part of this may have been due to Oprah was already being a social actor within African American culture. Another factor to consider is that Oprah did not talk about the narrative in isolation but in conversation with some of the actors within the narrative, a

man on the down low and a woman who had been a victim of the experience. This choice, to be a social actor in connection with other actors within the narrative may have helped to give a face to the narrative and make it more relatable.

How Context Informs Responsibility

Within this narrative, men on the down low are set up as the party responsible for African American women's experiences with HIV and AIDS. Tanisha explicitly articulated this when she said that she grew up being told, "make sure your man ain't on the down low, he's going to give you HIV." Within her memory, her community had publicly assigned responsibility to men on the down low. Having identified who is assigned responsibility, it is important to now turn to examine the context that reinforces blame.

In this study, communication of the down low narrative took place in both religious and public health contexts because these narratives were told as part of research examining how to implement a HIV and AIDS intervention within African American churches. The church is an important institution within African American communities, shaping African Americans' worldviews and socio-cultural systems (Frazier, 1969; Lincoln & Mamiya, 1990). The religious setting becomes the context for the narrative that men on the down low are responsible for African American women's HIV rates of acquiring HIV.

Alexander posited that when traumatic narratives are interpreted within a religious context those hearing the narrative will often search for a reason for why the group's deity (in this case the Christian God) allowed the trauma to happen. When thinking about the ways that a religious context informs how narratives of HIV and AIDS are told and

interpreted it is important to think about the ways that the institutional church shapes sexual ethics. Christian churches often have a strong set of ethical dogmas that dictate how individuals and couples are allowed to engage in sexual activity.

Barbra gave an example of the ways that this happens when she described how the church tries to label the presence of HIV within individual bodies as acceptable or unacceptable based on the individual who acquired the virus. Based on her example it is acceptable for African American women to be living with HIV if they have acquired it from a man on the down low because they were not engaging in immoral sexual behavior or a “wrong lifestyle.” This is a demonstration of the ways that the religious context informed both who was labeled as the victim of the trauma and who was responsible for it.

In line with Alexander’s theory, religious contexts prompt communities to question who strayed from a divine law, which is a catalyst for the traumatic event. Also in line with his theory, African American women maintain their victimhood status by assigning responsibility to another party. Assigning responsibility in this way creates, or reinforces, a religious identity. Additionally, it creates and reinforces how the victims and those assigned responsibility relate to God. Thus, it creates, and reinforces, the social relationship between victims and those assigned responsibility. In communities where the church is important, such as African American communities, religious identities and social identities can reciprocally inform each other.

The answer of responsibility for women’s HIV experiences is found in down low men for religio-social reasons. Community members perceive the Bible as prohibiting, or

condemning, MTMSA.²⁶ These, along with lived experiences, could inform how men on the down low, and GBMSM broadly, are perceived as engaging in risky sexual behaviors.

Barbra described perceptions that men on the down low, or those “living the wrong lifestyle,” have acquired HIV in a socially unacceptable manner thus they perceive that down low men’s acquisition of the illness becomes a condemnation of their sexual activity under the edicts of the Christian tradition. Like Alexander posits, Barbra’s church has found a way to answer the question of why something traumatic, in this case how an HIV acquisition, has happened to an innocent person. They find an answer in the lives of men on the down low. As such, differentiation in responsibility between “good HIV,” or innocent victimhood, and “bad HIV,” comes with how the behavior of the individual is perceived in relation to divine law. Because MTMSA is seen as sinful these participants assigned responsibility to men on the down low.

Men engaging in MTMSA perceived as theologically outside of the church because of their behavior. They are seemingly “othered,” because they exist outside of the spiritual and doctrinal church. Such othering of African American GBMSM also informs how African American women relate to men on the down low. Because these men are seen as the other, they can more easily be assigned responsibility for HIV transmission. Ironically, topics not commonly addressed in church spaces, HIV and AIDS, are raised as topics of conversation, allowing church members to comfortably address a “taboo” subject without really having to breach church doctrine. Further, because these conversations are happening within the church, church members can

²⁶ I say “perceptions” here because queer biblical scholarship continues to reinterpret the Bible in ways that support queer identity and sexual activity.

maintain their relationship with God while also approaching a sensitive subject—human sexuality and sexual transmission of diseases.

But there is more to this than the church members simply blaming men on the down low. As was seen in participants' discussions of MTMSA and homosexuality, many participants did not see themselves as being homophobic, but rather as against the "lifestyle" of homosexuality. This may be a common sentiment in African American churches in the U.S. (Fullilove & Fullilove, 1999; Valera & Taylor, 2011; Wilson, Wittlin, Munoz-Laboy, & Parker, 2011).

One justification that participants used when they assigned men on the down low responsibility for women's experiences acquiring HIV was that they perceived men on the down low to be engaging in risky sexual behaviors, although they did not identify the nature of these behaviors. If, as Alexander posits, communities seek to assign responsibility for trauma through a theodicean lens by identifying the behavior causing the pain as against divine law, then African American communities' belief that MTMSA are risky may be linked with the belief that they are immoral which contributes to the experience of othering GBMSM. Understandings of MTMSA as risky appear to be informed by participants' limited understandings of MTMSA. For many participants it is enough to perceive that MTMSA is prohibited by the Bible and to assume that it is not happening in their church. This may also lead to pain when individuals find out that someone they perceived to not be engaging in MTMSA do not align with the moral code their community follows. Yet, some men on the "down low" identify as bisexual and others identity as heterosexual while engaging in sexual activity with women and men. Unfortunately, there is not much scholarly literature on this aspect of the phenomenon of

the “down low.” Nonetheless, participants in this study share that “down low” sexual behavior is something that causes concern and confusion for this population.

Summarizing the Spiral

Alexander (2004) posits that as part of a spiral of signification social actors must articulate the pain of an event, name the victim of the pain, and assign responsibility for the pain in a way that is relatable to their target audience. Participants in this study inductively described all of these constructs. African American women and in particular Oprah, name themselves as innocent individuals who acquire HIV and are victimized by men on the down low, who transmit HIV to them after engaging in risky sexual behavior on the down low.

Christian theodicy plays a large part in this process as African American women in the church try to understand why God would allow them to suffer through unknowingly acquiring HIV by a partner they have perceived as heterosexual. They answer this question by naming men on the down low as responsible for their experience with HIV. This takes place within religious contexts that name and reinforce MTMSA as going against divine law.

The narrative and its context shape how African American Christian women see themselves in relation to others, both other women in the church and to men on the down low, and other GBMSM. Because women are situated as innocent victims, they receive certain attention and services in relation to HIV and AIDS interventions and care that GBMSM in the church might not receive. Hence, they become the target population for HIV and AIDS interventions and receive more attention than other populations that are more highly affected by illness and disease transmission.

Conclusion: Religio-Social Identity in Relation to HIV and AIDS

African American communities, particularly in the southern US, are disproportionately affected by HIV and AIDS. Within these communities, women are particularly affected. While GBMSM bear a significantly higher incidence and rate ratio of HIV, participants predominantly named African American women as the most affected subpopulation in the US. While this is a misperception, a general misunderstanding of statistics does not provide a nuanced picture of what is happening within African American churches and communities.

Two narratives of HIV emerged inductively during this study: Magic Johnson's public disclosure of his HIV status and African American men on the down low transmitting HIV to African American women. While narratives of Magic Johnson in this data set did not fully meet all Alexander's theoretical constructs, they cannot be discounted for their importance within African American communities. The narrative may still aid in the formation of religio-social identity in nuanced ways because they draw on ideas of hope, which is a concept that is also found in some Christian theologies. More notably, however, the narrative of men on the down low met all the theoretical constructs and requirements and appears to be a primary way that African American Christian women construct religio-social identity in relation to HIV and AIDS.

Treichler (1999) articulated the ways that communities, and American society, broadly, discuss, dichotomize, negotiate, and define HIV and AIDS as part of peoples and groups constructing their social identity. Following from this, this study examined the ways that African American women form identity in relation to HIV and AIDS, and thus define it. Participants broadly defined HIV as something that disproportionality

affects African American women. Additionally, participants who espoused a narrative of men on the down low define HIV as a virus that is transmitted to them from men on the down low, who are perceived as engaging in risky sexual behaviors, such as having multiple sexual partners. For the definitions put forward, Treichler would categorize this particular case in terms of subpopulations whose social identity is shaped based on being affected by HIV and AIDS. Interestingly, this definition also delineates between acceptable and unacceptable ways of acquiring HIV.

African American women have felt victimized by HIV transmission within their sexual relationships and have thus utilized theodicy when constructing an identity that identifies them as having acquired HIV in an acceptable manner. Because social concepts, definitions, and identities are always in relation with each other, and are often dichotomous, women's construction of an acceptable way of acquiring HIV also indicates that there must be an unacceptable way of acquiring HIV. Because women's construction of having acquired HIV in an acceptable way is centered within their feelings of victimization, the most direct social relationship is to those that they can assign an unacceptable status to, reinforcing feelings of victimization. This process is also catalyzed by religious understandings of MTMSA as unacceptable. Thus, one way that African American women define HIV in relation to African American men on the down low.

Halbwachs differentiates between history and memory in a similar way that Townes (2006) draws on Morrison, differentiating between fact and truth. This dichotomy emerged in this work as well, reflecting the difference between epidemiological data of HIV incidence and women's perceptions of who was most

affected by HIV. Seeking to understand the truth that African American women's narratives of HIV and men on the down low calls for an examination of the ways that these narratives act as countermemory. When white, heteronormative hegemonic memory does not include narratives of HIV, African American women sought to form their own narratives that helped them make meaning of their experiences with HIV and added to their sense of social identity. When creating this memory African American women drew on an existing source of meaning making: the African American church.

Understanding the narrative examined here as countermemory opens up the narrative to examine the truth of lived experiences rather than to focus on "facts." Alexander's theory of signification provides a framework for examining countermemory and truth. The theory calls for an examination of the pain of the experience, feelings of victimization, and social relationships with those assigned responsibility. The truth of women's experience in relation to pain indicates their experiences with men on the down low are meaningful because they bring the possibility of living with a chronic health condition for the rest of their lives. Further, the truth is even more challenging to accept if they believed their sexual partner was heteronormative but was not, and/or did not fully disclose their HIV status or and MTMSA they had engaged in.

Through examining the truth of women's descriptions of being victims in this narrative, it appears to speak to the deep hurt and betrayal felt when finding out that partner was living on the down low in addition to the pain of unexpectedly being diagnosed with a chronic health condition. An important note about being diagnosed with HIV is that many participants who shared this narrative is that they described down low men as "giving" them HIV, rather than that they had acquired HIV or that it had been

transmitted.²⁷ The narrative suggests that women feel like they are helpless and vulnerable to men on the down low, who they believe can transmit HIV to them at any time, even though the women themselves did nothing that they perceived as increasing their susceptibility to acquiring HIV.²⁸

Implications of this Study for Health Education

Public health literature has not given much attention to how public health practitioners frame the issue of HIV/AIDS prevention programs or the terminology they use when discussing these programs with church leaders. Yet, Treichler (1999) suggests that it is important to understand, as there are many different ways that communities within America define and make meaning of HIV and AIDS. For public health professionals implementing HIV and AIDS interventions in African American churches and communities it is important to segment the community into the group that will be reached by the intervention so that it can be framed appropriately. This is already being done as the majority of interventions in African American churches are already designated specifically for women.

When conducting interventions, it will be important to increase HIV prevention self-efficacy and social support. This narrative indicates that women feel victimized when they acquire HIV. One way to address this may be to focus efforts not only on teaching HIV prevention skills, such as correct condom usage, but also to focus on how to increase HIV prevention self-efficacy. This may involve addressing gender norms in African American

²⁷ Public health terminology intentionally stays away from using the term “give” and utilizes the terms “acquire” and “transmit” in their appropriate contexts (UNAIDS, 2015).

²⁸ Again, it’s important to note that UNAIDS and other HIV and AIDS organizations identify this as a harmful and problematic way of thinking about HIV and AIDS within communities (UNAIDS, 2015).

churches and increasing women's agency within relationships. This suggestion builds on and corroborates previous research utilizing this dataset regarding gender roles that African American churches dictate for women (Piper et al., 2019). Additionally, the narrative suggests that women feel pain if/when relationships break apart after an HIV diagnosis. Thus, it may be useful to seek to increase social support among women in the church.

Limitations of this Study

Qualitative research ontologically possesses several limitations (Hennink et al., 2010). Qualitative research seeks to understand experiences or perceptions deeply, rather than broadly, thus it cannot be generalizable to broader populations. The research cannot speak to the prevalence of an idea within a community. Additionally, this research examined a narrative that emerged from the data inductively, or without interviewers asking specific questions about it. Thus, we cannot be sure if more participants held this narrative or if others had more detailed perceptions about it.

This study was a secondary analysis of inductive themes, which carries limitations in itself. The TEACH project was not seeking to learn about these narratives and thus interviewers did not probe for further information or details when participants described this narrative, which means that there may be further details or nuance to examine in future studies. Therefore, perceptions about the deceptive nature of down low behavior were not probed for when participants did not explicitly talk about them; this constitutes a limitation of this study, as such information would have aided the present analysis. Future research in this area may specifically ask about this as a means of gaining a more nuanced understanding of the variety of factors informing these perceptions.

Additionally, this research was conducted as a secondary analysis, several years after data collection and coding was completed, thus it may represent perceptions held at the time of data collection, but social and cultural shifts since 2016 may have shifted narratives or added further nuance to them. Finally, the TEACH project was explicitly oriented towards studying HIV and AIDS interventions in African American churches and participants had volunteered to implement an HIV prevention intervention for African American women aged 18-30 in their churches. Thus, participants may represent a self-selection bias where only participants interested in this topic and preventing HIV transmission in their communities registered. Additionally, naming the target audience of the intervention may have biased participants to believe that African American young women are the most affected by HIV and AIDS.

Concluding Summary

African American communities, particularly women are highly affected by HIV and AIDS. Public health research continues to examine how to effectively and meaningfully conduct HIV and AIDS interventions in African American churches because they are important social institutions in African American communities. Examining perceptions and narratives of men on the down low transmitting HIV to women suggest that women are deeply hurt by these experiences and that the narrative is broadly relatable to women in African American communities. These narratives are utilized when constructing a social identity that is contextualized by African American churches' rejection of MTMSA. This suggests that interventions may need to continue to increase self-efficacy and social support among women in African American churches.

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Appendix A: Participant Pseudonyms and Demographic Characteristics

Table 3. Individual Demographic Characteristics of Quoted Participants

Pseudonym	Age	Gender	Marital Status	Educational Level	Healthcare Professional	HIV Tested	Size of Church
LaTasha	32	Female	Single or Never Married	Started or Completed Masters/PhD	Yes	Yes	Large
Desiree	29	Female	Single or Never Married	Started or Currently Enrolled in College	Yes	Yes	Large
Ashley	35	Female	Married	Started or Completed Masters/PhD	Yes	Yes	Large
Debra	60	Female	Widowed	Started or Completed Masters/PhD	Yes	Yes	Mega-Church
Albert	53	Male	Unknown	Unknown	No	Unknown	Mega-Church
Teresa	60	Female	Divorced	Started or Completed Masters/PhD	No	Yes	Mega-Church
Sonya	54	Female	Divorced	Graduated College	Yes	Yes	Mega-Church
Latrice	42	Female	Divorced	Graduated College	No	Yes	Large
Kymerly	54	Female	Divorced	Completed Associates Degree	No	Yes	Large
Aliyah	26	Female	Single or Never Married	Started or Completed Masters/PhD	Yes	No	Large
Katrina	24	Female	Single or Never Married	Started or Currently Enrolled in College	Yes	Yes	Medium
Sabrina	43	Female	Married	Started or Currently Enrolled in College	Yes	Yes	Mega-Church

Pseudonym	Age	Gender	Marital Status	Educational Level	Healthcare Professional	HIV Tested	Size of Church
Pamela	51	Female	Single or Never Married	Graduated College	Yes	Yes	Mega-Church
Wayne	62	Male	Married	Started or Completed Masters/PhD	No	Yes	Mega-Church
Stacey	39	Female	Single or Never Married	Started or Completed Masters/PhD	No	Yes	Mega-Church
Beverly	52	Female	Married	Completed Associates Degree	No	Yes	Large
Allison	48	Female	Married	Graduated College	No	Yes	Large
Carla	51	Female	Divorced	Graduated College	Yes	Yes	Unknown
Glenda	53	Female	Divorced	Started or Completed Masters/PhD	Yes	Yes	Unkown
Mae	60	Female	Married	Graduated College	No	Yes	Large
Tanisha	30	Female	Single or Never Married	Started or Completed Masters/PhD	No	Yes	Mega-Church
Lisa	46	Female	Married	Graduated College	Yes	Yes	Large
Aletta	68	Female	Married	Graduated College	Yes	Yes	Mega-Church
Dorothy	60	Female	Widowed	Started or Completed Masters/PhD	No	Yes	Large
Rene	48	Female	Divorced	Completed Associates Degree	Yes	Yes	Large

Pseudonym	Age	Gender	Marital Status	Educational Level	Healthcare Professional	HIV Tested	Size of Church
Monica	56	Female	Divorced	Started or Completed Masters/PhD	No	Yes	Mega-Church
Erica	56	Female	Divorced	Graduated High School/GRE	No	Yes	Mega-Church
Barbra	72	Female	Divorced	Started or Completed Masters/PhD	Yes	No	Mega-Church
Alexandria	26	Female	Single or Never Married	Graduated College	No	Yes	Large
Tina	46	Female	Single or Never Married	Started or Completed Masters/PhD	No	No	Mega-Church
Latoya	28	Female	Married	Started or Completed Masters/PhD	No	Yes	Large
Maureen	68	Female	Divorced	Started or Currently Enrolled in College	No	No	Mega-Church
Veronica	44	Female	Single or Never Married	Started or Completed Masters/PhD	No	Yes	Large
Ella	52	Female	Married	Started or Completed Masters/PhD	Yes	Yes	Mega-Church
Brenda	46	Female	Married	Started or Completed Masters/PhD	No	No	Mega-Church
Janice	47	Female	Married	Completed Technical School	Yes	Yes	Large